Driven PHYSICAL THERAPY
Col. 3: 23-24

28 Holly Creek Drive
Anderson, SC 29621
DrivenPTSC.com
864.305.2956

Registration Form

Today's Date:
Referring Physician:

PATIENT INFORMATION

Last Name: _____ First: _____ Middle: _____

Is this your legal name? If not, what is your legal name? ☐ Yes ☐ No. Legal Name: _____

Marital Status (Circle One) Mr. / Mrs. / Miss / Divorced / Separate / Widow Birthdate: / /

Gender: ☐ Male ☐ Female

Street Address (P.O. Box): _____

City: _____ State: _____ ZIP_____ Preferred Phone Number: _____

Occupation: _____ Employer: _____ Work phone no.: _____

Email Address: _____

Referred by: ☐ Doctor ☐ Family ☐ Friend ☐ Close to Home/Work ☐ Other: _____

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: _____ Birthdate: / /

Address (If Different): _____

_____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other: _____ Phone: _____

Employer: _____ Employer address: _____

Work Phone: _____ _____

Is this patient covered by insurance? ☐ Yes ☐ No

Primary Insurance: _____ Subscriber's Social Security: _____

Birthdate: / / Policy no.: _____ Group no.: _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Secondary Insurance: _____ Subscriber's Social Security: _____

Birthdate: / / Policy no.: _____ Group no.: _____

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

IN CASE OF EMERGENCY

Emergency Contact: _____ Relationship to patient: _____

Primary Phone: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Driven Physical Therapy. I understand that I am financially responsible for any balance. I also authorize Driven Physical Therapy or insurance company to release my information required to process my claims.

Patient/Guardian: _____ Date: _____

CANCELLATION / NO-SHOW POLICY

Dear Patient,
We understand that periodically you may have to cancel or reschedule your appointment. In the event that you are unable to make your scheduled appointment, please contact our office as soon as possible to cancel or reschedule. It is likely that another patient is waiting for a cancellation in order to receive treatment; therefore, please give us 24 hours notice if you are unable to make your appointment.

Two or more cancellations without 24 hours notice and/or "no-shows" will result in a charge to your account of $35.

_____ _____
Patient Name Date of Birth

_____ _____
Patient/Guardian Signature Date

_____
Name if signing on behalf of patient

Informed Consent for Physical Therapy Care

Physical therapy is the evaluation or treatment of a person by the use of the effective properties of physical measures and heat, cold, light, water, electricity, sound, and air; and the use of therapeutic massage, therapeutic exercise, mobilization, and the rehabilitative procedures with or without assistive devices for the purposes of preventing, correcting, or alleviating a physical or mental disability, or promoting physical fitness and well-being.

Patient Rights

- All persons who seek physical therapy care have the right to service regardless of age, gender, race, nationality, religion or politics.
- Clients have the right to refuse physical therapy services.
- Clients have the right to privacy, confidentiality, self-determination including participation in decisions about care, cease therapy, and access to second opinion.
- Expect that the physical therapist shall provide consultation, evaluation, treatment, and preventative care in accordance with the laws and regulations of South Carolina.

Patient Responsibilities

- Provide your clinician complete and accurate health and insurance information concerning illness, hospitalizations, allergies and function.
- Request additional information when you do not understand.
- Inform your clinician if you anticipate problems complying with the treatment plan.
- Demonstrate respect and consideration for other patients and facility staff.
- Notify your clinician of any changes in your condition.

I hereby request and consent to the performance of physical therapy procedures. I wish to rely on the doctor to exercise judgment during the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest. I have read the above consent. I have also had the opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature: _____ **Date:** _____

(or Signature of Legal Guardian)

HIPAA Privacy Compliance
Acknowledge of Receipt of Notice Privacy Practices

Health Insurance Portability and Accountability Act (HIPAA)

HIPAA's Privacy Rule requires that providers with a direct treatment relationship make a good faith effort to obtain an individual's written acknowledgment of receipt of the Notice of Privacy Practices.

Privacy Standard/Rule (HIPAA)

The Privacy Rule sets the standards for how protected health information (PHI) "in any form or medium" should be controlled. This Rule took effect in April 2003 for large entities, and a year later for small ones.

Privacy Rule protections extend to every patient whose information is collected, used or disclosed by covered entities. It imposes responsibilities on the entire workforce of a covered entity -- including all employees and volunteers -- in order to secure those rights. It also requires contractual assurances for any business associates of health care institutions that handle health care information on a covered entity's behalf.

Our Notice of Privacy Practice provides information about how we may use and disclose protected health information about you. It explains how we may use it for the purpose of treatment, payment of treatment, and as required/ permitted by law. The notice may be subject to change or revision. If changes or any revisions are made to our notice, you may obtain a revised notice by request.

By signing below, you acknowledge that you were provided a copy of the notice *upon request* on the date indicated below.

Patient Name: _____ Patient/ Guardian Signature: _____

Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ○ Individual refused to sign.
- ○ Communications barriers prohibited obtaining the acknowledgement.
- ○ An emergency situation prevented us from obtaining acknowledgement.
- ○ Other (Please Specify) _____

Employee Signature: _____ Date: _____

Medical Information Release Form
(HIPAA Release Form)

Privacy Standard/Rule (HIPAA)

The HIPAA Privacy Rule permits covered entities to share information that is directly relevant to the involvement of a spouse, family members, friends or other persons identified by a patient, in the patient's care or payment for healthcare. If the patient is present, or is available prior to disclosure, and has the capacity to make health care decisions, the covered entity may discuss this information with the family and other persons if the patient agrees or, when given the opportunity, does not object.

☐ I authorize the release of information including diagnosis, records; examination rendered to me and claims information. This information may be released to:

- ☐ Spouse _____
- ☐ Child(ren) _____
- ☐ Other _____
- ☐ Information is not to be released to anyone.

*This **Release of Information** will remain in effect until terminated by me in writing.*

Patient Name: _____

Patient/Responsible Party Signature: _____

Date: _____

Patient Medical History

Name: _____ Date: / /

Reason for Visit/Chief Complaint: _____

_____

Driven PHYSICAL THERAPY
Col. 3: 23-24

Height: _____ Weight: _____

Medical Conditions

Diabetes: ☐ Yes ☐ No Dementia: ☐ Yes ☐ No

Depression: ☐ Yes ☐ No Bipolar Disorder: ☐ Yes ☐ No

List any medical conditions that you have (asthma, hypertension, high cholesterol, cancer history, etc.)

Current Medications:

Do you take any medications? ☐ Yes ☐ No

(Include vitamins, aspirin, Tylenol, Ibuprofen, supplements, birth control, topical creams, etc.)

Medication	Strength/How often?	Medication	Strength/How often?

Surgical History (Include: C-Sections, Tonsillectomy, Gallbladder, oral, etc.)

Date of Surgery:	Type of Surgery:

Pain Rating Scale

Name: _____ Date: _____

Pain Now: (Within the last 48-72 hours)

0	2	4	6	8	10
No Pain ☐	Mild Discomfort ☐	Moderate Pain ☐	Severe Pain ☐	Very Severe Pain ☐	Worst Pain Imaginable ☐

Pain at its <u>WORST</u>: (Within the last 48-72 hours)

0	2	4	6	8	10
No Pain ☐	Mild Discomfort ☐	Moderate Pain ☐	Severe Pain ☐	Very Severe Pain ☐	Worst Pain Imaginable ☐

Pain at its <u>LEAST</u>: (Within the last 48-72 hours)

0	2	4	6	8	10
No Pain ☐	Mild Discomfort ☐	Moderate Pain ☐	Severe Pain ☐	Very Severe Pain ☐	Worst Pain Imaginable ☐

Please mark your pain on the image.