ETC Physical Therapy & Sports Medicine

PATIENT REGISTRATION

Date:

Last Name, First Name, Middle Initial		Home Phone #		Cell Phone #
Street Address	City	State	Zip	
Date of Birth	Social Security #	Gender	Marital Status	Email Address

Did you see us here: ☐ Website ☐ Google ☐ Facebook ☐ Twitter ☐ Instagram ☐ Yelp ☐ Post Card ☐ Email ☐ Other ☐ Did someone refer you to ETC? We'll send them a Thank You!

Is your condition related to: (If other, please describe)

☐ EMPLOYMENT? ☐ AUTO? ☐ OTHER?

If so, which state?	Date of Accident?	Attorney's Name & Number (If applicable)

Employment Information:

Employer Name	Occupation/Department	Work Email Address

Spouse or Responsible Party Information (If different from above)

Name	Relationship to patient	Home Phone	Cell Phone
Street Address	City	State	Zip
Date of Birth	Social Security #	Employer	Employer's Address & Work Phone

In Case of Emergency Contact

Emergency Contact Name	Home Phone	Cell Phone	Relationship to Patient

Assignment & Release

I, the undersigned, have insurance coverage with _____, and assign directly to Exercise Therapy Consultants, Inc., all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize ETC, Inc. to release all information necessary to secure the payment of benefits. I AUTHORIZE the use of this signature on all my insurance submissions whether manual or electronic.

_____

Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Exercise Therapy consultants, Inc. for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____

Signature of Insured/Guardian Date

WORKERS COMPENSATION

I, the undersigned, have Worker's Compensation benefits with _____, and assign directly to ETC, Inc., all medical benefits, if any, otherwise payable to me for services rendered. I understand that I will be financially responsible for all charges if worker's compensation benefits are denied. I hereby authorize ETC Inc., to release all information necessary to secure the payment of benefits. I AUTHORIZE the use of this signature on all my insurance submissions either electronic or manual.

_____

Signature of Insured/Guardian Date

PATIENT HISTORY FORM

Name	Referring Physician	Date of your next appt. with your physician

Regarding this injury:

Date of first Dr. visit — Last Date Worked

Returned to Work

Did you have surgery for this injury? YES NO — Type? — Where/When

Are you aware of your diagnosis? (check one) YES NO

Have you ever had Physical Therapy before? YES NO

List any known allergies

List medications you are currently taking

For this injury:

Have you had any of the following rehabiltative services?

Chiropractor	☐
General Practicioner	☐
Myelogram	☐
Orthopedist	☐
Emergency Room	☐
CT Scan	☐
Massage Therapy	☐
Neurologist	☐
Physical Therapy	☐
X-Rays	☐
EMG/NCV	☐
MRI	☐
Occupational Therapy	☐
Podiatrist	☐
Other	☐

Please indicate if you have had previous orthopedic injuries or surgeries

Neck injury/surgery	☐
Shoulder injury/surgery	☐
Elbow injury/surgery	☐
Hand injury/surgery	☐
Back injury/surgery	☐
Knee injury/surgery	☐
Leg injury/surgery	☐
Joint Replacement	☐
Physical Therapy	☐
Pins or metal implants	☐
Other	☐

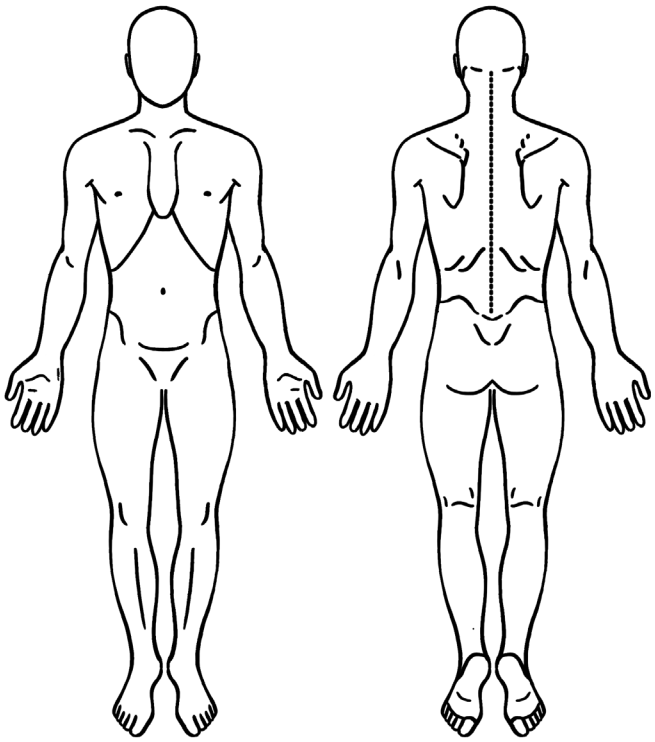
Do you now have or have you ever had any of the following?

Asthma, Bronchitis, or Emphysema	☐
Shortness of Breath / Chest Pain	☐
Coronary Artery Disease	☐
Do you have a pacemaker?	☐
High Blood Pressure	☐
Heart Attack or Surgery	☐
Stroke / TIA	☐
Blood Clot / Emboli	☐
Epilepsy / Seizures	☐
Thyroid Disorder	☐
Infectious Diseases	☐
HIV Positive	☐
Diabetes	☐
Cancer / Chemotherapy / Radiation	☐
Arthritis / Swollen Joints	☐
Osteoporosis	☐
Gout	☐
Sleeping Disorder / Difficulties	☐
Emotional / Psychological Disorders	☐
Recent Changes in Bowel or Bladder	☐
Severe or Frequent Headaches	☐
Recent Changes to Vision or Hearing	☐
Dizziness or Fainting	☐
Numbness or Tingling	☐
Unexplained Weakness	☐
Unexplained Weight Loss / Energy Loss	☐
Hernia	☐
Varicose Veins	☐
Do you Smoke?	☐
Are you currently Pregnant?	☐

CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for ETC Physical Therapy to furnish medial care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical & mental condition.
PATIENT FULL NAME

Patient/Guardian Signature: _____ Date: _____



Using the key below, please indicate your current symptoms & locations on the diagram:

Stabbing	//////////////
Burning	XXXXXX
Numbness	=======
Pins & Needles	0000000
Aching	SSSSSS

Describe your Pain & Symptoms:

How often do you experience your current symptoms?
☐ Always ☐ Frequently ☐ Occasionally ☐ Seldom

What activites aggravate your symptoms?

What activites relieve your symptoms?

Have you tried ICE and/or HEAT? ☐ YES ☐ NO

What are your goals for therapy?

(1)_____
(2)_____
(3)_____

FOR OFFICE USE ONLY

I have reviewed the above information/conditions with patient/guardien prior to evaluation and treatment
I have instructed the patient on their plan of treatment
I have reviewed the patient's rehabilitation potential prior to treatment

Therapist Signature: _____ Date: _____

I, _____, understand and accept the treatment explained.
PATIENT FULL NAME

_____
SIGNATURE

Attendance/Payment Policies

1. Payment is expected at the time services are rendered unless prior arrangements have been made. This includes Deductibles and Co-Payments.

2. If a remaining balance is owed after your treatment has been processed through your health insurance, you are fully responsible for that balance. Any account with an outstanding balance must make payment at time of next visit.

3. It is your responsibility to make sure your insurance has approved your visit to ETC Physical Therapy. We are happy to assist you in this process. Please make sure your insurance company has been contacted before you see the Physical Therapist.

4. Insurance filing is done as a courtesy for our patients. We cannot guarantee payment by your insurance company. We will file your claims in a timely manner to the insurance companies you have provided. We expect payment in return in a timely manner. Balance will not be carried over 60 days unless prior arrangements have been made. If your claim has been denied for any reason, it may become your responsibility.

5. If you are receiving medical services that will be covered by means other than health insurance (such as Auto Insurance due to an MVA or attorney reimbursement, etc.): If you have Med Pay or PIP we will bill under that insurance first, and when the maximum is reached, we will bill your health insurance. The balance remaining will be your responsibility. If you have no health insurance, you will be expected to pay $100 at your initial evaluation and $50 per visit TOWARDS your balance, until settlement of your case.

6. If you have been involved in a personal injury, the Insurance Commissioners of Kansas & Missouri request that you provide all information on your health insurance, the personal injury insurance covering you, and the third party/other driver. IT IS UNLAWFUL TO WITHHOLD THIS INFORMATION.

7. If you are a Workers Compensation Claimant: In the event that your claim for Worker's Compensation benefits are denied, all services rendered to you will be charged directly to you and you are then responsible for full payment.

8. Cancellation of appointments require 24-hour advance notice, otherwise, we will charge the patient a late cancellation/no show fee of $100. This fee must be paid BEFORE the patient is able to reschedule another appointment. This fee is not the responsibility of the insurance carrier, nor will they pay for the fee.

9. Failure to show to two consecutive appointments will result in your removal from our schedule. A follow-up call will be placed to the patient. If no attempt is made by the patient to schedule another appointment, the patient will be discharged from physical therapy services until a new prescription is provided by the physician.

10. In the event you fail to make payment when due, your account may be placed with a third party for collections which will result in the patient becoming responsible for attorney fees, collections fees, court costs, and finance charges. This debt will also be reported to all three main credit bureaus.

11. As per insurance guidelines, please sign in and out at each appointment.

_____ Copy given to patient on _____

Signature of Patient Date Employee Initial & Date

Consent to Email Usage

Patients in our practice may be contacted via email to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email address.

☐ Email _____ _____

Patient's Signature Date

Consent for Photographing or Other Recording for Security

I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment, or healthcare operations purposes or otherwise permitted or required by law.

_____ _____

Patient's Signature Date

Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

Name	Relationship	Contact Number

Financial Responsibility Acknowledgement

I understand that I am 100% financially responsible for medical service provided by Exercise Therapy Consultants, Inc. (ETC). ETC will bill my insurance as a courtesy, applying all applicable network discounts.

While ETC does verify benefits for the patient, the patient should contact their insurance company to ensure they are aware of their financial responsibility. If for any reason ETC is provided incorrect benefits, it is still the patient responsibility to pay their portion of the treatment provided per their insurance benefits.

Patient will be subject to a $40.00 per month late fee for each month after 60 days that the patient's responsibility remains in arrears.

In the event that the patient fails to pay their outstanding balance within the 90 days they will be subject to court proceeding resulting in additional fees. These fees will include time and travel (Current mileage fees X round trip miles to the court house.) , court costs as directed by the court itself and any process servers' charges.

_____ _____

Signature of Insured/Guardian Date

Acknowledgement of Receipt of "Notice of Privacy Practices"

By my signature below, I acknowledge only that I have been shown and offered a copy of ETC Physical Therapy's
"Notice of Privacy Practices" (Located behind this page)

_____ _____

Patient's Signature Date

_____

Patient's Printed Name

**This acknowledgement page must be copied and given to patient, in addition, the original must remain with ETC Physical Therapy

Effective Date: April 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact E.T.C. Physical Therapy, Belton, MO 816-331-9111.

OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of protected Health Information.
- Give you this notice of our legal duties and privacy practices regarding Health Information about you.
- Follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

Described as follows are the ways we may use and disclose Health Information that identifies you. Except for the following, you may revoke such permission at any time by writing to our practice's privacy officer.

Treatment We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel. This includes people outside our office who are involved in your medical care and need the information to provide you with medical care.

Payment We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so they will pay for your treatment.
Health Care Operations We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the physical therapy services you receive are of the highest quality. We also may share information with entities that have a relationship with you (your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services We may use and disclose Health Information to contact you and remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives, billing or payment issues, or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care When appropriate, we may share Health Information with a person who is involved in your medical care or payments for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research Under certain circumstances we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS

As Required by Law We will disclose Health Information when required to do so by international, federal, state, or local law.

To Avert a Serious Threat to Health or Safety We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures however, will be made only to someone who may be able to help prevent the threat

Business Associates We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Military and Veterans If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.
Workers' Compensation We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; inform a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and report to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include; audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement We may release Health Information if asked by a law enforcement official if the information is: In response to a court order, subpoena, warrant, summons, or similar process; Limited information to identify or locate a suspect, fugitive, material witness, or missing person; About the victim of a crime even if under certain very limited circumstances we are unable to obtain the person's agreement; About a death we believe may be the result of criminal conduct; About criminal conduct on our premises; In an emergency to report a crime, the location of the crime or victims, or the identify, description, or location of the person who committed the crime.

Coroners, Medical Examines, and Funeral Directors We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities We may release Health Information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be made if necessary; For the Institution to provide you with health care; To protect your health and safety or the health and safety of others; or for the safety and security of the correctional institution.

YOUR RIGHTS

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information you must make your request, in writing, to E.T.C. Physical Therapy P.O. Box 320, Belton, MO 64012.

Right to Amend If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to E.T.C. Physical Therapy P.O. Box 320, Belton, MO 64012.

Right to an Accounting of Disclosures You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment, and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to E.T.C. Physical Therapy P.O. Box 320, Belton, MO 64012.

Right to Request Restrictions You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to E.T.C. Physical Therapy P.O. Box 320, Belton, MO 64012. We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential Communication You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. To request confidential communication, you must make you request, in writing, to E.T.C. Physical Therapy P.O. Box 320, Belton, MO 64012. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice You have the right to a paper copy of this notice. You may ask us to give you copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact E.T.C. Physical Therapy at 816-331-9111. All complaints must be made in writing. You will not be penalized for filing a complaint.

Cancellation/No Show Policy

Patients are expected to provide at least 24 hours notice if they wish to cancel their physical therapy appointments. Patients who do not provide at least 24 hours notice prior to their appointments start time may be charged a $100 late cancellation/no show fee, and will not be allowed to schedule their next appointment until this fee is paid.