(1) PATIENT INFORMATION

Name: _____
Last Name First Name Initial

Address: _____

_____ Apt# _____

City: _____ State: _____ Zip:_____

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

E-mail address: _____

Sex: M : __ F __ Birth date: _____

Social Security #: _____

Occupation: _____

IN CASE OF AN EMERGENCY, CONTACT:

Name: _____ Relation: _____

Phone #: _____

How did you hear about us? _____

_____

(2) INSURANCE INFORMATION

Health Insurance: (*Primary):* _____
Insurance Phone: _____

Policyholder name: _____

Relationship to policyholder: _____

Policy #: _____ Group #: _____

Health Insurance: (*Secondary):* _____

Insurance Phone: _____

Policyholder name: _____

Relationship to policyholder: _____

Policy #: _____ Group #: _____

(3) AUTO ACCIDENT/ WORKERS COMPENSATION

Date of injury: _____

Owner of vehicle: _____

Insurance Carrier/Phone:_____

Policy #: _____

Claim #: _____

Attorney (if known): _____

Phone: _____

(4) ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE

I CERTIFY THAT I HAVE READ AND RECEIVED NOTICE OF PRIVACY PRACTICES AND THAT ALL MY QUESTIONS REGARDING THE HIPPA HAVE BEEN ANSWERED AS THEY PERTAIN TO MY PROTECTED HEALTH INSURANCE (PHI).

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

(5) AUTHORIZATION FOR TREATMENT

I hereby authorize the physical therapist to treat my condition as he/he deems appropriate and to furnish any authorized request for information regarding treatment. The patient also agrees that he/she is responsible for all bills incurred at this office. (The physical therapist will not be held responsible for any preexisting medically diagnosed conditions nor for any medical diagnosis). The patient also agrees that statements made in this questionnaire are true and correct.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

AYAM DE LEON, PTPC
PATIENT PRIVACY AND HIPAA REGULATIONS
(HIPAA = Health Insurance Portability and Accountability Act)

1. The patient may revoke this approval at any time **in writing.**
2. If the patient requests that his/her records be released, they **must** complete an authorized release form. The release **must** specify to whom the records are to be released.
3. You have the right to ask that incorrect or incomplete information in your medical record be corrected.

CONFIDENTIALITY

All Patient records are strictly confidential and are the property of AYAM DE LEON, PTPC and will never be discussed with anyone outside the facility, or inside the facility within hearing distance of other patients.

DISSOLUTION

1. In the event of the dissolution of AYAM DE LEON, PTPC, all records will be stored by a designated service at that time.
2. Prior to dissolution, all patients treated within the previous three (3) years will be notified in writing of the pending dissolution. Patients will be given the opportunity to receive copies of records prior to dissolution. Patients will be notified of the name, address and phone number of the designated service in the event records are needed at a future time.

PATIENT RECORDS

1. When not in use, all patient records shall be kept in fire resistant cabinets.
2. Overnight, the cabinet doors shall be kept closed.
3. All clerical personnel shall safeguard patient information.

Electronic Safeguards have been established according to HIPAA standards. Personnel shall not walk away from a computer having patient information on the screen.
The fill shall be closed.

Patient's Printed Name: _____

Patient's Signature: _____ Date: _____