

## REGISTRATION FORM

### PATIENT INFORMATION

Patient's Last Name		First	Middle	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	Marital Status				
						<input type="checkbox"/> Sgl	<input type="checkbox"/> Mar	<input type="checkbox"/> Div	<input type="checkbox"/> Sep	<input type="checkbox"/> Wid
Is this your legal name? <input type="checkbox"/> Yes <input type="checkbox"/> No		If not, what is your legal name?		(Former Name)		Birth Date	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F		
Street Address		City	State	ZIP Code	Social Security #		Home Phone No. ( )			
Referral Physician <input type="checkbox"/> Dr. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.		Doctor's Phone No. ( )		Doctor's Fax No. ( )		Cell Phone No. ( )				
Doctor's Address		City	State	ZIP Code	Work Phone No. ( )					
Primary Care Physician (if different from referral source) <input type="checkbox"/> Dr.						Doctor's Phone No. ( )				
Doctor's Address		City	State	ZIP Code	Doctor's Fax No. ( )					
E-mail address										

### INSURANCE INFORMATION

(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST TO COPY)

Patient's Relationship to Subscriber		<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Partner	<input type="checkbox"/> Other				
Subscriber (if not patient)		Birth Date	Address (if different)			Home Phone No. ( )				
Is this person a patient here?		<input type="checkbox"/> Yes	<input type="checkbox"/> No							
Policy #		Primary insurance			<input type="checkbox"/> Aetna	<input type="checkbox"/> Blue Cross HMO	<input type="checkbox"/> BCBS	<input type="checkbox"/> Cigna	<input type="checkbox"/> MVP	<input type="checkbox"/> UHC
<input type="checkbox"/> Worker's Comp (specify company)		<input type="checkbox"/> Motor Vehicle (specify company)			<input type="checkbox"/> Other					
WC or NF Street Address		City			State	ZIP Code				
WC / NF caseworker name		Caseworker's phone #	Extension	claim #	Date of injury					
Occupation	Employer	Employer Address			Work phone ( )					
Person authorized to schedule appointments for you					Phone #					
Person authorized to discuss billing for you					Phone #					

### IN CASE OF EMERGENCY

Name of Local Friend or Relative (if possible, someone not living at same address)		Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )
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The above information is true to the best of my knowledge and I authorize treatment. I authorize my insurance benefits to be paid directly to Callan-Harris PT, PC. I understand that I am financially responsible for any balance. I also authorize Callan-Harris Physical Therapy, PC or insurance company to release any information required to process my claims.

X

\_\_\_\_\_  
PATIENT / GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

## *Clinic policies*

- If you are running 10 or more minutes late for your appointment, we may have you reschedule so as not to put the therapist behind in their schedule.
- Our Physical Therapy practice requires a 24-hour notice for all cancellations. If a scheduled appointment must be cancelled within 24 hours of the scheduled time, there will be a charge equal to your co-payment (or a fee of \$20.00 if your insurance does not require a co-payment for visits to a specialist). If you are a no-show for your appointment, the same charge will be applied. We are holding the time spot for you and may be able to give the time to another patient who has requested a visit.
- Should you have more than 3 missed appointments or cancellations with less than 24 hours notification, we will no longer schedule your appointments in advance. You may call on the day you would like to be seen to inquire if any appointments are available.
- **If your insurance requires referrals, we need to be sure that one is in place prior to your visit. Our office can get them set up for you if your doctor has not already done so. When your referral runs out, you may be liable for full payment if your insurance company denies the visit.**
- There will be a \$5 charge for any bill that needs to be mailed to you for payment on your account, so please stop at the desk to take care of your co-pays when you arrive at the office.
- If you are not sure of your co-pay amount, we will charge \$20 at the time of service and adjust after insurance remittance.
- Our office phone is not for personal use, so please do not ask our personnel if you may make a call.
- We ask that you not talk on your cell phones in the waiting area as it disturbs other patients and makes it difficult for our personnel to communicate with patients in the waiting area.
- Please do not wear perfume/cologne to your visit. Many of our patients and staff have sensitivities to strong scents.

Thank you for helping us to keep things running smoothly.

\_\_\_\_\_  
Patient signature / date

### **Patient consent form (HIPAA)**

By signing this form, you are granting consent to Callan-Harris Physical Therapy to use and disclose your protected health information for the purpose of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent and we encourage you to read it in full.

(There is a copy hanging on bulletin board in the waiting room, or you may ask for your own personal copy.)

Our Notice of Privacy Practices is subject to change. If we change our notice, we will post it in the waiting room. We encourage you to request a copy of the revised policy.

You have the right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I verify that I have been offered a copy of Notice of Health Information Privacy Practices

Initial \_\_\_\_\_

# FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment. I agree that parents, guardians, or other personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all services or items provided to me, to my minor/child, or to the patient to whom I have legal responsibility. I understand that my health insurance may not pay for bandages, tape, ionto/hybrisis patches, tubing, Theraband, or other items necessary for my treatment because the items/service may not be a covered benefit under my insurance policy. I understand that if the cost of this service is not paid (in full or at all) by my insurance, that I will be responsible for the cost. I hereby agree to pay Callan-Harris Physical Therapy for the cost of the item or service if it is not covered by my insurance.

**I understand that filing a claim with my insurance company does NOT relieve me from my responsibility for the payment of all charges.**

SELF PAY patients are required to pay in full for charges incurred at the time services are rendered. Payment plans are available as a courtesy . please speak with the office manager to set this up.

All co-payments are due at time of service and I understand that a \$25.00 fee will be charged for any returned checks.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

## INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_  
Name of insurance company(ies)

and assign directly to Callan-Harris Physical Therapy, P.C. all insurance benefits, if any, otherwise payable to me for services rendered.

**I understand that I am financially responsible for all charges incurred whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I understand that there may be a limit to the number of visits my insurance allows and will pay the hourly rate per visit when exceeding that limit.**

The above-named practice may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed.

Initial \_\_\_\_\_

## APPOINTMENT CANCELLATION POLICY

### ***Important information for our patients:***

Our Physical Therapy Practice requires a 24 hour notice for all cancellations. If a scheduled appointment must be cancelled within 24 hours of the scheduled time, **there will be a charge equal to your co-payment (or a fee of \$20.00 if your insurance does not require a co-payment for visits to a specialist). If you are a no show for your appointment, the same charge will be applied.** We are holding the time spot for you and may be able to give the time to another patient who has requested a visit.

Should you have have more than 3 cancellations on day of appointment and/or missed appointments- you will only be allowed to call in on the day you would like to be seen to see if any appointments are available.

Initial \_\_\_\_\_ Date \_\_\_\_\_

Parent or guardian's initials (if under age 18) \_\_\_\_\_

*Callan-Harris Physical Therapy, PC*  
Patient Medical History/Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Are you taking any prescription or over-the-counter drugs? Yes No      If yes, please list each one below:

\_\_\_\_\_

Height: \_\_\_\_\_ Weight \_\_\_\_\_

Do you currently smoke? Yes No If yes, how much? \_\_\_\_\_

Have you previously smoked? Yes No If yes, how long before you quit? \_\_\_\_\_

If you are a female, could you be pregnant or are you attempting to become pregnant? Yes No

What is the furthest you could walk before taking a break? (time or distance) \_\_\_\_\_

Have you ever had and/or been treated for any of the following disease or medical problems? (check all that apply)

- Abnormal Bleeding
- Anemia
- Asthma, wheezing, or inhaler use
- Arthritis (osteo, rheumatoid) \_\_\_\_\_
- Back/Neck pain/problems
- Balance Problems
- Broken Bones \_\_\_\_\_
- Cancer/Chemotherapy/Radiation/Tumors
- Circulation/Vascular problems
- Deep Vein Thrombosis
- Depression or Anxiety
- Diabetes (insulin, medication) \_\_\_\_\_
- Difficulty Breathing
- Difficulty sleeping
- Dislocated/Swollen Joints \_\_\_\_\_
- Drug/Alcohol Abuse
- Eating Disorder
- Emphysema or other Lung Disease
- Epilepsy/Seizures
- Fainting Spells/ Dizziness
- Fever Blisters
- Fibromyalgia
- Gastrointestinal Problems \_\_\_\_\_
- Hay Fever
- Head Injury \_\_\_\_\_
- Heart Disease, irregular pulse
- Hearing or Vision Loss/Disturbance
- High / Low Blood Pressure \_\_\_\_\_
- Heart Murmur/Mitral Valve Prolapse
- Heart Surgery/ Pacemaker
- Hepatitis A, B, C
- Kidney Problems \_\_\_\_\_
- Multiple Dystrophy/Multiple Sclerosis
- Parkinson's Disease
- Psychiatric Problems \_\_\_\_\_
- Severe Headaches
- Shingles/ Skin disease \_\_\_\_\_
- Sinus Problems
- Spinal Cord Injury \_\_\_\_\_
- Stroke \_\_\_\_\_
- Thyroid condition
- Tuberculosis
- Ulcers
- Venereal Disease

## Callan-Harris Physical Therapy, PC

Please list any other medical condition(s) you have ever had: \_\_\_\_\_

**Please list any drug, latex, food, or other allergies not previously mentioned?** \_\_\_\_\_

Please list any surgeries you have had. \_\_\_\_\_

How do you spend your day now: \_\_\_\_\_

What would you like to do that you cannot now: \_\_\_\_\_

List 1-2 things you want therapy to do for you: \_\_\_\_\_

I understand the above information is necessary to provide me with effective therapeutic care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Callan-Harris Physical Therapy, PC

Callan-Harris Physical Therapy, P. C. 1328 University Avenue, Rochester, New York 14607-1622

Phone: 585-482-5060 Fax: 585-482-7982 E-mail: chptusa@gmail.com

## Authorization for Release of Medical Information

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip Code: \_\_\_\_\_  
Patient's Phone #: ( ) \_\_\_\_\_  
Date of Request: \_\_\_\_\_ Date Needed: \_\_\_\_\_

<input type="checkbox"/> I authorize Callan-Harris PT to release information to:	<b>OR</b>	<input type="checkbox"/> I authorized Callan-Harris PT to obtain information from:
_____ Name of Provider or Facility		_____ Name of Provider or Facility
_____ Address		_____ Address
_____ City/State/Zip Code		_____ City/State/Zip Code
_____ Phone #/Fax# (include area code)		_____ Phone #/Fax# (include area code)

PURPOSE FOR THIS REQUEST: (Check one)  Healthcare  Insurance coverage  Personal  Other

TYPE OF RECORDS REQUESTED: (Check one)

Inpatient date(s) \_\_\_\_\_  Outpatient date(s) \_\_\_\_\_

Specific information (Select one or more as applicable)

Operative report  History & Physical  Discharge Summary  Laboratory Test Results

X-Ray Reports  Physical Therapy  Other \_\_\_\_\_

Please describe

Treatment summary (includes history/physical, laboratory tests & x-ray reports, operative reports, pathology)

Entire copy of the inpatient/outpatient record checked above

All medical records related to a specific illness or injury

Specify illness/injury \_\_\_\_\_

Date(s) of treatment \_\_\_\_\_

AUTHORIZATION VALID FOR: (Check one)

This request only

One year from the date of this authorization OR \_\_\_\_\_ (insert date). This authorization applies to the records of the treatment received on or prior to the date of this authorization.

This request and for medical records of any future treatment of the type described above until: \_\_\_\_\_ (insert date).

I understand that:

- \* My right to healthcare treatment is not conditioned on this authorization.
- \* I may cancel this authorization at any time by submitting a written request to the address provided at the top of this form, except where a disclosure has already been made in reliance on my prior authorization.
- \* If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
- \* Release of HIV-related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- \* There may be a charge for the requested records.

**NOTE: Medial records are faxed in cases of medical necessity only**

Signature of Patient or Representative \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient (if requester is not the patient) \_\_\_\_\_