1328 University Ave, Rochester, NY 14607
Phone (585) 482-5060
Fax (585) 482-7982

Name:_____ DOB:___/___/___
(First Middle Initial Last)

REGISTRATION FORM

PATIENT INFORMATION

Patient's Last Name	First	Middle	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital Status ☐ Sgl ☐ Mar ☐ Div ☐ Sep ☐ Wid

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former Name)	Birth Date	Age	Sex ☐ M ☐ F

Street Address	City	State	ZIP Code	Social Security #	Home Phone No. ( )

Referral Physician ☐ Dr. ☐ NP ☐ PA	Doctor's Phone No. ( )	Doctor's Fax No. ( )	Cell Phone No. ( )

Doctor's Address (if other than local)	City	State	ZIP Code	Work Phone No. ( )

Primary Care Physician (if different from referral source) ☐ Dr.	Doctor's Phone No. ( )

Doctor's Address (if other than local)	City	State	ZIP Code	Doctor's Fax No. ( )

E-mail address — May we contact you by e-mail? ☐ Yes ☐ No

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

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Child ☐ Partner ☐ Other

Subscriber (if not patient)	Birth Date	Address (if different)	Home Phone No. ( )
Is this person a patient here? ☐ Yes ☐ No			

Policy # Group # — Primary insurance ☐ Aetna ☐ Blue Cross HMO ☐ BCBS ☐ Cigna ☐ MVP ☐ UHC

☐ Worker's Comp (specify company) ☐ Motor Vehicle (specify company) ☐ 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. ( )

The above information is true to the best of my knowledge. 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.

Signature: _____ *Date:* _____

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Name:_____ DOB:___/___/___
(First Middle Initial Last)

Patient Information Height: _____ Weight _____ Occupation _____

Reason for Therapy:_____ Date of onset/injury/surgery: _____

Goal(s) in Therapy: _____

Please list any prescription **OR** over-the-counter drugs: (include dose, frequency, and what it is taken for)

_____

_____

Currently smoke? ☐No ☐Yes, how much?_____ Previously smoked? ☐No ☐Yes, how long? _____

Could you be pregnant or are you attempting to become pregnant? ☐No ☐Yes

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
___ Osteoporosis / Osteopenia
___ Parkinson's Disease
___ Psychiatric Problems _____
___ Severe Headaches
___ Shingles/ Skin disease _____
___ Sinus Problems
___ Spinal Cord Injury _____
___ Stroke _____
___ Thyroid condition
___ Tuberculosis
___ Ulcers
___ Venereal Disease

Other medical condition(s): _____

_____

Allergies (including drug, latex, food, etc): _____

_____

Prior surgeries: _____

_____

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.

Signature: _____ *Date:* _____

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Name:_____ DOB:___/___/___
(First Middle Initial Last)

Our office is a teaching clinic. We have students and interns with our PTs on occasion. If you would prefer NOT to have a student sitting in and/or assisting with your visit/treatment, please let us know prior to your visit.

_____ *Initial*

We realize that your time is valuable and we will strive to run on time so as to minimize waiting. Please realize that our reserved time is also valuable to us. **There will be a charge of $40 for each missed appointment.** If you find you must cancel your scheduled appointment, please give us 24 hours' notice in advance to avoid the charge.

_____ *Initial*

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.

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.

_____ *Initial*

I verify I have been offered a copy of Notice of Health Information Privacy Practices (on file at front desk)

_____ *Initial*

Financial Agreement

Payment (or copay) is due at the time of services whether covered by an insurance company or SELF PAY.

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 some items may not be covered by insurance. (Non-covered items may include bandages, tape, ionto patches, Theraband, etc.) I understand that filing a claim with my insurance company does NOT relieve my responsibility for the payment of all charges.

Payment plans are available as a courtesy – please speak with the office manager to set this up.

Explanation of Fees: $5 for any bill that needs to be mailed to you,
$25.00 for returned checks

_____ *Initial*

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 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.

If your insurance requires a preauthorization, one must be in place prior to your visit. We can set one up for you if your doctor has not already done so. When your preauthorization runs out, you may be liable for full payment if your insurance company denies the visit.

Signature: _____ *Date:* _____

ROCHESTER RHIO

Regional Health Information Organization

New York State Department of Health

Authorization for Access to Patient Information Through a Health Information Exchange Organization

PROVIDER: Callan-Harris Physical Therapy, PC

Patient Name	Date of Birth	Patient Identification Number
Patient Address		

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the above-named Provider Organization or Health Plan; or reference to a list of specific Provider Organizations and/or Plans attached to this form to obtain access to my medical records through the health information exchange organization called Rochester RHIO. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network. Rochester RHIO is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit Rochester RHIO's website at www.RochesterRHIO.org.

My information may be accessed in the event of an emergency, unless I complete this form and check box #2, which states that I deny consent even in a medical emergency.

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **I GIVE CONSENT** for above-named Provider Organization, or Health Plan or reference to a list of specific Provider Organizations and/or Plans to access ALL of my electronic health information through Rochester RHIO to provide health care services (including emergency care).

☐ **I DENY CONSENT** for above-named Provider Organization, or Health Plan or reference to a list of specific Provider Organizations and/or Plans to access my electronic health information through Rochester RHIO for any purpose, ***even*** *in a medical emergency (except for minor patients)*.

If I want to deny consent for all Provider Organizations and Health Plans participating in Rochester RHIO to access my electronic health information through Rochester RHIO, I may do so by visiting Rochester RHIO's website at www.RochesterRHIO.org or calling Rochester RHIO at 1-877-865-RHIO(7446).

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through Rochester RHIO and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:
    - **Treatment Services.** Provide you with medical treatment and related services.
    - **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
    - **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
    - **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization(s) and/or Health Plan(s) listed may access ALL of your electronic health information available through Rochester RHIO. This includes information created before and after the date this form is signed. Your health records may include clinical notes, discharge summaries, allergies, a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), treatments you have received, your diagnoses, and lists of medicines you have taken. These records may contain all of this information about sensitive health conditions, including but not limited to:
    - Alcohol or drug use problems
    - Birth control and abortion (family planning)
    - Genetic (inherited) diseases or tests
    - HIV/AIDS
    - Mental health conditions
    - Sexually transmitted diseases

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from the named Provider Organization(s) or Rochester RHIO. You can obtain an updated list at any time by checking Rochester RHIO's website at www.RochesterRHIO.org or by calling 1-877-865-RHIO(7446).

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one. If there is an emergency, doctors and other staff members will be able to use the Rochester RHIO to see the health information of patients who are minors.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through Rochester RHIO for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization at: _____; or visit Rochester RHIO's website: www.RochesterRHIO.org; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/*.

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as Rochester RHIO ceases operation (or until 50 years after your death whichever occurs first). If Rochester RHIO merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice(s). Organizations that access your health information through Rochester RHIO while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form.