TSPT
TIM SODER PHYSICAL THERAPY
WELLNESS & SPORTS PERFORMANCE

Patient Registration Form

Date:_____ **Treating Therapist:** _____

☐ New Patient ☐ Re-Start ☐ New Diagnosis ☐ New Insurance

Patient Name_____
Last First Middle Initial Nickname

Address _____
City State Zip

Home Phone_____ Work Phone_____ Mobile Phone _____

Social Security #_____ DOB_____ Gender: ☐ M ☐ F

Driver's License #_____ Email Address _____

Marital Status_____ **Employment Status**_____ **Student:** ☐ YES ☐ NO

Occupation_____ Employer_____ Employer Phone #_____

Address _____
City State Zip

Emergency Contact Name _____
Last First

Address _____
City State Zip

Relationship to Patient_____ Home Phone_____ Work Phone _____

Responsible Party_____
Last First

Address _____
City State Zip

Relationship to Patient_____ Home Phone_____ Work Phone _____

Social Security #_____ DOB_____ Gender: ☐ M ☐ F

Driver's License # _____

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Insurance Information

Primary

Name of Insurance Company_____

Insurance Phone # _____

ID Number_____

Group Number _____

Insurance Address _____

_____

Name of Insurance_____

OR ☐ Self

Insured Name _____

Insured Address _____

_____

Insured Phone # _____

Sex: ☐ M ☐ F DOB _____

SS #_____

Relationship to Insured

☐ Child ☐ Spouse

Secondary

Name of Insurance Company_____

Insurance Phone # _____

ID Number_____

Group Number _____

Insurance Address _____

_____

Name of Insurance_____

OR ☐ Self

Insured Name _____

Insured Address _____

_____

Insured Phone # _____

Sex: ☐ M ☐ F DOB_____

SS # _____

Relationship to Insured

☐ Child ☐ Spouse

ASSIGNMENT OF INSURANCE BENEFITS

1. The undersigned agrees, whether signing as agent or patient, and it hereby individually obligated to pay for services rendered to the patient in accordance with the terms of the company, which are not reimbursed by third parties. The undersigned further agrees to bear legal fees and collection expenses, which may be incurred by the company, in collection of payment on the amount, if that amount becomes delinquent.

2. The undersigned hereby authorizes treatment by Timothy Soder Physical Therapy and assigns to Timothy Soder Physical Therapy any and all benefits arising out of any type of insurance, which insures the patient's bill. The undersigned understands that the temporary acceptance of verified insurance coverage in lieu of payment does not release the patient from ultimate payment responsibilities. The undersigned acknowledges having received a copy of the Financial Policy Practices for Timothy Soder Physical Therapy.

3. The undersigned hereby authorizes Timothy Soder Physical Therapy to release any or all information to third parties, including but not limited to employers and insurance companies, who may be liable to the patient or Timothy Soder Physical Therapy for payment of charges to the patient.

4. Timothy Soder Physical Therapy reserves the right to modify the privacy practices outlined in the notice. The undersigned acknowledges having received a copy of the Notice of Privacy Practices for Timothy Soder Physical Therapy.

_____ _____

Patient Signature date

_____ _____

Entered By date

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Physician Information

Referring Physician: _____

Physician Phone #: _____

Date of Last Doctor Visit: _____

Date of next Doctor Visit: _____

Injury Information

Is condition surgery related? ☐ Yes ☐ No Date of Surgery _____

Surgical Procedure _____

Is condition accident related? ☐ Yes ☐ No Was an automobile involved? ☐ Yes ☐ No

Date of Accident _____ Describe Accident _____

_____

Were you injured on the job? ☐ Yes ☐ No Date of Injury _____

Are you currently working? ☐ Yes ☐ Full-time ☐ Part-time ☐ No

Name of employer at time of accident _____

Address _____
City State Zip

Describe Injury _____

_____

Is litigation involved? ☐ Yes ☐ No Name of Attorney _____ Phone # _____

_____ _____
Patient/Guardian Signature Date

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Patient Health History

Patient Name: _____
Last First Middle Initial

Patient Age_____ Height: _____ Weight: _____

When did the pain start?_____ Date of surgery:_____ Type of Surgery: _____

How did the pain start?

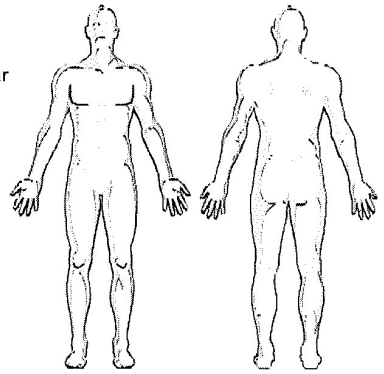
- ☐ Suddenly
- ☐ Gradually
- ☐ Lifting
- ☐ No apparent reason
- ☐ Pulling
- ☐ Injured at work
- ☐ Bending
- ☐ Fall

Pain/Symptoms:

On the Body Diagram to the right, indicate your region of pain using the symbols below:

(X) Sharp
(+) Numb/Tingling
(#) Dull/Aching
(B) Burning

Pain Scale: best current worst
0 10



Description of onset/injury: _____

_____

What activities make the pain worse?

- ☐ Exercise (during)
- ☐ Exercise (after)
- ☐ Sitting
- ☐ Walking
- ☐ Other _____
- ☐ Bending forward
- ☐ Bending backwards
- ☐ Coughing
- ☐ Sneezing

What reduces the pain?

- ☐ Lying down
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Anti-inflammatories
- ☐ Other _____
- ☐ Pain pills
- ☐ Injection for pain
- ☐ Muscle relaxants
- ☐ Nothing

Have you had any of these diagnostic tests?

X-rays	☐ Yes	☐ No
CT Scan	☐ Yes	☐ No
EM G/NCV	☐ Yes	☐ No
MRI	☐ Yes	☐ No
Arthrogram	☐ Yes	☐ No
Injections	☐ Yes	☐ No

Have you had physical therapy for your problem?

☐ Yes ☐ No If Yes, Date_____

Have you been hospitalized for your problem?

☐ Yes ☐ No If Yes, Date_____

Have you had any other surgery performed?

☐ Yes ☐ No If Yes, Date_____

Place a check to any of the following that apply to you:

- ☐ Allergies
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Heart Disease
- ☐ Stroke (CVA)
- ☐ Cancer or tumors
- ☐ Lung Problems
- ☐ Arthritis-joint difficulties
- ☐ (Ir)regular headaches
- ☐ Blackouts
- ☐ Seizures-nerve disorders
- ☐ Visual problems
- ☐ Immunity disorders
- ☐ Gout
- ☐ Pregnant
- ☐ Joint replacement
- ☐ Night sleep disturbance
- ☐ Change in bowel or bladder habits
- ☐ Change in stool color or rectal bleeding
- ☐ Increased thirst or hunger
- ☐ Frequent urination
- ☐ Indigestion or heartburn
- ☐ Nausea or vomiting
- ☐ Changes in memory
- ☐ Dizziness
- ☐ Fever or chills
- ☐ Frequent or easy bruising or bleeding
- ☐ Frequent cramping
- ☐ Experience pain 24 hrs
- ☐ Wake up from pain
- ☐ Smoke_____#/Day
- ☐ Drink_____#/Day

What medications are you currently taking? _____

_____

What other types of doctor/health care providers have you seen for this condition? _____

_____

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Patient Name:

Date:

MEDICATIONS	DOSAGE

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FINANCIAL POLICY

Thank you for choosing Tim Soder Physical Therapy as your healthcare provider. Our mission is to provide the highest quality care to every patient, every appointment, every day.

Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which you are required to read and sign prior to treatment.

- All patients must complete our patient information, patient history & HIPAA policy forms before seeing a provider
- Current insurance cards & photo ID must be presented at check-in to be scanned into our system
- Full payment is due at the time of service for cash patients unless prior arrangements have been made
- Copays, co-insurance, and deductible payments are due at time of check-in for insured patients
- We accept cash, check, debit cards, Visa, Mastercard, American Express, Discover & HSA cards
- There is a $30 service fee for all returned checks, your insurance does not cover this fee
- Any balance due from prior visits must be paid prior to any subsequent visit
- All accounts 90 days past due will be automatically assigned to a collection agency unless prior arrangements have been made
- If the account is turned over to a collection agency, patient agrees to pay all expenses our practice may incur in collecting the delinquent balance. Collection fees are 40% of the balance owed and will be due in addition to the outstanding balance
- Any patient who fails to show up for their appointment and does not call to cancel at least 24 hours in advance, will be charged a $30.00 fee
- Please know that waiving deductible and copayment charges are illegal and a breach of our contract with the insurance companies

INSURANCE COVERAGE

If your insurance company requires a referral from your physician, it is your responsibility to obtain the referral from your physician and bring it with you to your visit. If you do not have a referral and your insurance company requires it, we may have to reschedule your appointment.

Thank you for your understanding and cooperation. Please let us know if you have any questions or concerns.

I have read the financial policy described above and understand and agree to all of its provisions.

_____ _____

Signature of the patient or responsible party Date

_____

Print name of patient or responsible party

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HIPAA Notice of Privacy Practices

PLEASE READ THIS DOCUMENT IN ITS ENTIRETY

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operation.

- TREATMENT means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be sending medical information to the referring physician.
- PAYMENT means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill and/or chart notes for your visit to your insurance company for payment.
- HEALTH CARE OPERATIONS include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be sending charts to the physical therapy network for quality assurance review.

We may also create and distribute de-identified healthy information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders, reschedule appointments, or provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

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PLEASE READ THIS DOCUMENT IN ITS ENTIRETY

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive and accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post, and you may request a copy of the revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:
TSPT
Attention: Office Manager
6440 Medical Center #100
Las Vegas, NV 89148

For more information about HIPPA or to file a complaint:
The US Department of Health & Human Services
Office of Civil Rights
200 Independence Ave SW
Washington, DC 20201
Toll Free: 1-877-696-6775

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Tim Soder Physical Therapy's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

Please allow access to my Protected Health Information (PHI) to my: spouse, child, parent, guardian, other

Patient Name: _____

Relationship to Patient: _____

_____ _____

Signature Date