

Notice of Privacy Practices

You are entitled to full confidentiality of your records as maintained by Back on Track under Federal and State guidelines (42 CFR 2.22). In most cases this means that your records cannot be released unless you specifically authorize that release in writing. Please be aware that Back on Track personnel may exchange information freely within the clinic, but that neither Back on Track nor its employees may disclose to an outside individual or agency that you are a patient receiving services, the nature of those services or the condition for which you are seeking treatment.

Your confidential information may only be released if:

- a) You consent in writing on an approved Release of Information form, or
- b) The disclosure is forced by a legitimate court order, or
- c) The minimal information necessary is disclosed to medical personnel in a medical emergency.

You have a right to inspect and obtain a copy of your patient record, with the understanding that portions of the record may be withheld if they are determined to be detrimental to your physical and/or emotional health. One copy of your record will be provided at your request without cost. Additional copies may be obtained with a \$25.00 copy fee.

Acknowledgement and Consent to Treat

I understand there are certain risks inherent to any physical endeavor. Every effort will be made to minimize these risks by providing me adequate instruction and supervision. I understand clear and direct communication between my therapist and me is necessary to ensure my safety and well-being. Nonetheless, in rare instances, injury may occur.

I have read, understand and agree to the above rights and responsibilities for patients of Back on Track. In signing, I consent to be treated by the therapists and staff of Back on Track (Randa & Wahl, a Physical Therapy Corporation).

Signature

Date

Print your name here

Important information regarding your account!

Releases and billing instructions

Statement of financial responsibility (does not apply to worker's comp)

I understand that I am responsible for the payment of this account, and hereby assume and guarantee prompt payment of all expenses incurred. I understand that I am responsible for payment of outpatient office charge at the time of the visit. Back on Track will bill my insurance, but I am responsible for any deductible, co-pay or co-insurance which may be due according to the terms of my insurance policy.

Initial _____

Notice of "non-covered" services (does not apply to worker's comp)

Back on Track will make every effort to confirm the terms of your coverage prior to treatment, however final determination will not be made by your carrier until they receive our bill. I understand that should insurance coverage not be available, I am ultimately responsible for my account.

Initial _____

Bill To/ Payment Instructions (does not apply to worker's comp)

I hereby authorize and request Back on Track to bill my insurance company for physical therapy services provided to me. I also authorize payment of medical benefits to Back on Track for any services provided to me and billed by Back on Track.

Initial _____

Permission to release medical information

I authorize Back on Track to release information from my medical record, or from the medical record of the person for whom I am legally responsible, to my/their insurance company, other third party payers or their reviewing agencies. This information must be limited to that which is necessary to expedite claim processing. This authorization is valid for every visit to Back on Track until written notice revoking it is provided.

Initial _____

I release Back on Track of all responsibility for loss of confidentiality through access and/or copies made of records released in compliance to this authorization.

I have read all of the above and understand/agree to all provisions therein regarding responsibility for payments and release of information.

Patient's signature: _____

Date _____

Registration Form

Patient name _____
First Last Nickname

Birth date ____ / ____ / ____ SS# _____

Mailing address _____

City _____ State _____ Zip _____

Gender: M F Marital status S M D Other

Home/ Cell phone _____ Work phone _____

Employer _____ Occupation _____

Student Y N School _____

Referring MD _____ PCP _____

What is injured? _____

Date of injury/ onset _____ Date of Surgery _____

Is this condition related to: employment auto accident other accident

Do you have an attorney? Y N Auto Insurance Med Pay Y N

Named insured (if different from patient):

Name _____
First Last

Relationship to patient: Self Spouse Parent Other

SS# _____ Birth date ____ / ____ / ____ Gender: M F

Address (if different) _____

City _____ State _____ Zip _____

Insurance Information

Primary _____

Secondary _____

PATIENT HISTORY FORM

Today's Date _____

Name _____

Are you currently working? No Modified Duty Full-duty

Have you had surgery for this injury? Y N Date of surgery? _____

DESCRIBE PRESENT ILLNESSES:

Do you have any heart disease, heart trouble or heart abnormality? Y N _____

Do you have high blood pressure? Y N _____

Any recent or long term problems with your lungs? Y N _____

Do you have diabetes? Y N _____

Have you ever had cancer? Y N _____

Do you have metal implants? Y N _____

Do you have other illnesses? Y N _____

Have you used steroidal medication in the last year? Y N _____

SURGERIES:

Any previous surgeries? When?: _____

SPECIAL TESTS:

Have you had a recent X-Ray? Results? _____

Have you had a recent CT Scan? Results? _____

Have you had a recent MRI? Results? _____

MEDICATIONS:

Please list all medications you are presently taking:

