



Welcome to Ascent Physical Therapy

Patient Registration Form

How did you hear about us?(circle one): Referring physician Family/Friend Former Patient
Internet Insurance Self-Referral Work Comp/Social worker Social Media

Patient Name: Date of Birth:

SSN # Email Address:

Address: City: State: Zip:

Home# Cell # Marital Status: Gender:

Emergency contact: Telephone # Relationship:

Employer: Phone:

Address:

Referring Physician : Family Physician :

Onset Date (injury, accident, surgery date or recent date symptoms started):

Is injury related to Auto Accident Employment Other?

PERSON RESPONSIBLE FOR PATIENT (to be used if patient is a minor or insurance is carried by someone other than patient)

Name:

SSN # Relation to Patient:

Date of Birth: Home Phone: Cell #

Address:

Insurance Subscriber's Name: Subscriber's Date of Birth:

PATIENT SIGNATURE: DATE:

(Parent or Guardian Signature if patient is a minor)



Authorizations & Financial Policy

Patient Name: _____ Date of Birth: _____

Consent for Treatment and Release of information

I hereby authorize the staff of Ascent Physical Therapy to examine and treat me with physical therapy procedures and modalities necessary for the injury/diagnosis for which I have presented here.

Ascent Physical Therapy is hereby authorized to disclose all or any part of my medical record to third party payers, health care institutions, physicians, employer, attorney, case manager, adjustor and others directly involved in my care, as it relates to my treatment and/or payment for services provided.

Assignment of Benefits:

I authorize the release of any medical or other information necessary to determine benefits payable for Physical Therapy or related services. I request payment of Physical Therapy services or other services be made directly to Ascent Physical Therapy. In the event my insurance company forwards payment directly to me, I will deliver such payment to Ascent Physical Therapy and authorize Ascent Physical Therapy to deposit the checks that were made in my name.

Insurance: A) I understand it is my responsibility to call my insurance company ahead of time, to verify eligibility, obtain any pre-authorization that is necessary, and get an estimate of my benefits. B) I understand that any out-of-network charges are my responsibility. C) I further understand that I am responsible for all amounts not paid by my insurance company.

Co-Pays, Deductible and Coinsurance: Co-Pays, Deductibles and Coinsurance are due at the time of service unless prior arrangements have been made.

Returned Checks: Our office will charge \$25.00 for all returned checks.

Attendance and Cancellation Policy: It is important that the patients adhere to all scheduled appointments. If you need to cancel or reschedule your appointment, please give us 24-hour-notice. **If you do not provide 24-hour-notice, you will be charged \$50.00 payable before your next appointment** with the exception of illness and emergencies. **The practice reserves the right to discharge the patient if two or more appointments are missed with or without notice.**

Payments: If the balance due to Ascent Physical Therapy for services rendered becomes delinquent and is referred to an attorney and/or third party for collection, it is understood and agreed that Ascent Physical Therapy shall be entitled to recover costs and expenses incurred in the collection of any such delinquent amounts. In addition, Ascent Physical Therapy is authorized to charge 1-1/2% per month interest on a delinquent account.

Notice of Privacy Practices (HIPAA Acknowledgement/Consent):

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations. By your signature, you acknowledge that you understand the information in this document and agree to certain obligations.

Patient or Parent/Guardian Signature: _____ Date: _____



A Body in Motion Stays in Motion

Patient Medical History

1. Do you now have OR have you ever had ANY of the following? (Just mark the "Yes" conditions)

- ___ Asthma, Bronchitis, or Emphysema
___ Shortness of Breath/Chest Pain
___ High Blood Pressure
___ Coronary Heart Disease or Angina
___ Heart Attack or Heart Surgery
___ Pacemaker
___ Congestive Heart Disease
___ Stroke/TIA
___ Blood Clot/Emboli
___ Epilepsy/Seizures
___ Hernia
___ Diabetes
___ Cancer - Location:
___ Infectious Disease - Type:
___ Arthritis: [] Rheumatoid [] Osteoarthritis
___ Osteoporosis
___ Bowel or Bladder Problems
___ Emotional/Psychological Problems
___ Sleeping Problems/Difficulty Sleeping
___ Severe OR Frequent Headaches
___ Numbness OR Tingling
___ Dizziness OR Fainting
___ Weight Loss OR Loss of Energy
___ General Weakness
___ Do You Use Tobacco?
___ If Female , Pregnant - ___ weeks/months

Previous Injuries/Surgeries

- ___ Neck ___ Hip
___ Back ___ Knee
___ Shoulder ___ Leg
___ Elbow ___ Ankle
___ Hand ___ Foot

2. List any other information that would assist us in your care: _____

3. Allergies: _____

4. Medications _____, or [] See Medication List provided

5. Circle any that apply to your current condition:

- Work-related injury Motor vehicle accident
Athletic/recreational injury Lifting injury Falling injury
Recurring injury Unknown cause Other: _____

6. Please briefly describe your current symptoms:

7. Have you had ANY of the following Medical Services or Treatment related to your current condition?

- ___ X-Rays ___ MRI ___ CT Scan
___ EMG/NCV ___ CT Scan ___ Occupational Therapy
___ Physical Therapy ___ Chiropractic ___ Other: _____

If Yes, When and for what conditions? _____

I, THE UNDERSIGNED, STATE THAT I HAVE ANSWERED THIS QUESTIONNAIRE TO THE BEST OF MY KNOWLEDGE.

Patient/Guardian Signature: _____ Date: _____



Notice of Privacy Practices - HIPAA

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer questions from your family, close friends, or others involved in the payment of your care

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Submit insurance claims
- Help with public health and safety issues
- Do research
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here and in our Authorizations & Financial Policy.

Changes to the Terms of this Notice

We may change the terms of this notice, and the changes will apply to all personal health information you provide. The new notice will be available upon request and on our web site. This notice applies to Ascent Physical Therapy/Trinity Rehab Services, Inc. in North Vernon, IN

For more detailed information see:

<https://www.ascentpt.net/new-patient-forms>

<http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html>