KEIZER PHYSICAL THERAPY

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PATIENT INFORMATION

NAME _____ GENDER _____ AGE _____ BIRTHDATE _____

MAILING ADDRESS _____ CITY _____ ZIP _____

PHONE _____ SSN _____ MARITAL STATUS _____

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ BUSINESS PHONE _____

MEDICAL HISTORY

BRIEFLY DESCRIBE THE CONDITION OR INJURY WHICH BRINGS YOU TO PHYSICAL THERAPY:

AREA OF BODY INVOLVED _____ DATE OF INJURY _____

IF INJURY, WHERE AND HOW DID IT OCCUR? _____

_____

MEDICATIONS _____ REFERRING PHYSICIAN _____

OTHER MEDICAL CONDITIONS _____

INSURANCE INFORMATION

NAME OF COMPANY _____ CLAIM / ID # _____ GROUP # _____

OTHER INSURANCE _____ INSURED PERSON _____

OTHER ID NUMBERS _____ ATTORNEY _____

ASSIGNMENT AND RELEASE OF RECORDS

I AUTHORIZE **KEIZER PHYSICAL THERAPY** TO RELEASE MY MEDICAL INFORMATION TO MY INSURANCE COMPANY / ATTORNEY / THIRD PARTY PAYORS. MY INSURANCE BENEFITS FOR PHYSICAL THERAPY TREATMENT I HEREBY ASSIGN TO KEIZER PHYSICAL THERAPY. I AM FINANCIALLY RESPONSIBLE TO THE PHYSICAL THERAPIST FOR ANY CHARGES NOT COVERED BY THIS ASSIGNMENT.

PATIENT / GUARDIAN SIGNATURE _____ DATE _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
(TO BE RETAINED BY KEIZER PHYSICAL THERAPY)

I understand that Keizer Physical Therapy (referred to below as "the clinic") will use and disclose **health information** about me in the course of providing physical therapy care to me.

I understand that my health information may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand that the clinic is permitted to **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult with, and coordinate with other health care providers in the course of my treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative, and business functions that support the clinic's ability to provide me with appropriate care and arrange for payment.

I also understand that I have the right to receive a written **Notice of Privacy Practices** which describes how the clinic uses and discloses health information, the information practices followed by the clinic staff, and my rights regarding my health information.

I also understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request. I also understand that a copy of the most current version of the clinic's Notice of Privacy Practices in effect is available in the waiting / reception area and at **keizerpt.com**

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the clinic is not required by law to agree to such requests.

By signing below, I agree that I have reviewed / understand the information above and that I have received a copy of the Notice of Privacy Practices.

PATIENT _____ DATE _____

-OR-

PATIENT REPRESENTATIVE _____ DATE _____

DESCRIPTION OF REPRESENTATIVE'S AUTHORITY _____