PATIENT DEMOGRAPHICS/DEMOGRAFICA DE PACIENTE

PATIENT INFORMATION/INFORMACCION DEL PACIENTE			
Last name/Apellido:	**First/Nombre:**	**Middle/Segundo Nombre:**	
Birth date/Fecha de Nacimiento:	**Marital status/Estado Civil:**	**Gender/Sexo:** ◯ M ◯ F	**SSN#:**
Address/Direccion:			
Home Phone/No. de Casa: ☐ Preferred/Preferido	**Cell Phone/No. del Cellular:** ☐ Preferred/Preferido	**Email/Correo Electronico:** ☐ Preferred/Preferido	
Occupation/Occupacion:	**Employer/Compania:**	**Employer phone/Numero del Trabajo:**	
Primary Care Physician/Doctor Primario:		**Referring Physician/Doctor de Referrido:**	
Phone/No. de telefono:		**Phone/No. de telefono:**	
How did you hear about us?/Como supiste de nosotros?:			

INSURANCE INFORMATION/INFORMACCION DEL SEGURO			
(Please give your insurance card to the receptionist. Por favor entregue su targeta de seguro a la recepcionista.)			
Primary Insurance/Seguro Primario:	**Insurance Address/Direccion del Seguro:**		
Policy Holder Name/Nombre de asegurado:	**Birth date/Fecha de Nacimiento:**	**Group no.:**	**Policy no.:**
Patient's relationship to subscriber/ Relacion con el asegurado:			
Secondary Insurance/Seguro Secundario:	**Insurance Address/Direccion del Seguro:**		
Policy Holder Name/Nombre de asegurado:	**Birth date/Fecha de Nacimiento:**	**Group no.:**	**Policy no.:**
Patient's relationship to subscriber/ Relacion con el asegurado:			
Injured due to accident? _____Auto _____ Work **Lesionado por un accidente? _____Auto _____ Trabajo**	**Date of Injury/Fecha de accidente:**	**Insurance Name/Compañia de seguro:**	**Claim no./No. de reclamo:**

IN CASE OF EMERGENCY/EN CASO DE EMERGENCIA			
Emergency Contact/Contacto de Emergencia:	**Relationship to patient/Relacion con paciente:**	**Home phone/No. de Casa:**	**Cell Phone/No. del Cellular:**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Innovative Physical Therapy, LLC. I understand that I am financially responsible for any balance. I also authorize Innovtive Physical Therapy, LLC. or insurance company to release any information required to process my claims.

La información es verdadera a lo mejor de mi conocimiento. Autorizo que mis beneficios de seguro sean pagados directamente a Innovative Physical Therapy, LLC. Entiendo que soy financieramente responsable de cualquier saldo. También autorizo Innovative Physical Therapy, LLC. O la compañía de seguros para liberar cualquier información requerida para procesar mis reclamaciones.

Patient signature/Firma del Paciente **Date/Fecha**

INNOVATIVE
PHYSICAL THERAPY, LLC.

NO-SHOW AND CANCELLATION POLICY

In order for us to provide our patients with the highest level of service, Innovative Physical Therapy has instituted a no show and cancellation policy for all patients. We understand that our patients come to us with a range of physical pain and dire need for physical therapy; therefore, we are serious about accommodating our patients with their most convenient appointment slots.

Innovative Physical Therapy requests that office appointments be cancelled with a 24-hour notice. Failure to provide cancellation notice within the allotted time frame may be subject to a **$30.00 cancellation fee.** Patients who do not show up for their scheduled appointment without notification will be considered as a No Show. Failure to show up to a scheduled appointment will result in a **$50.00 No-Show fine**. Innovative Physical Therapy reserves the right to discharge a patient after three No-Shows and/or late cancellations to a scheduled appointment.

Exceptions to the No-Show/Late Cancellation policy are considered in emergency situations and are examined on a case by case basis. Manager approval is required on such instances.

Please sign and date acknowledging that you have read, understand, and agree to the terms of the No-Show and Cancellation policy.

_____	_____	_____
Patient Name (Please Print)	**Signature of Patient/Guardian**	**Date**

HIPAA Notice of Privacy Practices

Effective November 1, 2016

PLEASE REVIEW THIS NOTICE AS IT DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED, DISCLOSED, AND ACCESSED.

Innovative Physical Therapy pledges to protect your health information as required by law. In turn, we present the below notice as our legal duty to uphold privacy practices regarding your health information.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION:

Any information that may identify you is considered health information. Except for the below instances, we can only use and disclose your health information with your written permission. **You may revoke permission to use and disclose your health information at any time, in writing.**

Health information may be used to remind you of an appointment or provide you with information about treatment alternatives that may be of interest to you.

Health information may be disclosed to physical therapists, technicians, and/or other administrative personnel who require your information to provide you with treatment.

Health information may be disclosed to insurance companies, military and veteran offices, and third party billing in order to receive payment for treatment and services received.

Health information may be disclosed with your attorney for worker's compensation and automobile accident cases. **Written attorney authorization is required to disclose your health information to an attorney.**

Health information may be disclosed to a person who holds written consent to receive your information in instances where you are unable to communicate and/or are unresponsive. This person may be family, close friend, or emergency contact. **Written consent is necessary to disclose information to a friend or family.**

Health information may be disclosed when necessary and to specific individuals to prevent a serious threat to your health and safety or the health and safety of the public or another person.

YOUR RIGHTS:

You have the right to inspect and copy health information that may be used to make decisions about your treatment plan or payment for your treatment plan, including medical and billing records. A written request is for medical or billing records is required. Please note Innovative Physical Therapy reserves the right to charge you a fee for copying or mailing your documents.

You have the right to an electronic copy of electronic medical records. Please note Innovative Physical Therapy reserves the right to charge you for the labor associated with transmitting your electronic medical record.

You have the right to be notified of any breach of your protected health information. Additionally, you have the right to amend any health information that is incorrect or incomplete by providing a written request.

If you believe your rights have been violated, you have the right to file a written complaint with our office. You will not be penalized for such complaints.

Notice of Privacy Practices Acknowledgement Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPPA), I hold rights regarding my protected health information. I sign this form acknowledging that I have received and reviewed the HIPAA Notice of Privacy Practices notice containing a complete description of the uses and disclosures of my health information.

_____	_____	_____
Patient Name (Print)	Signature of Patient/Guardian	Date

If signed by a person other than the patient:

_____	_____	_____
Name (Print)	Relationship to Patient	Date

INNOVATIVE PHYSICAL THERAPY, LLC.

Name: _____

LIST OF CURRENT MEDICATIONS

List all prescription, over-the-counter, herbal, vitamin, and diet supplement products and any medicine you take only on occasion.

Medication	Dose (mg)	Times per Day	Reason for taking

Pain Assessment

No pain	Mild	Moderate	Severe	Very Severe	Worst pain possible
0	1-3	4-6		7-9	10

INNOVATIVE PHYSICAL THERAPY, LLC.