PATIENT REGISTRATION

_____ _____ _____ □ Male □ Female
Last Name First Name Age

_____
Street Address City State Zip Code

(_____) _____ (_____) _____ _____
Home Phone Cellular Phone Email Address

_____ - _____ - _____ _____ - _____ - _____ □ Single □ Married □ Other
Social Security Number Date of Birth

_____ (_____) _____
Emergency Contact Person Phone Number

_____ _____
Occupation Employer Name

Work Status: □ Currently Employed □ Retired □ Disabled □ Student

Is your condition related to a Work Injury? □ Yes □ No If yes, please list date of injury _____

If your condition related to an Auto Accident? □ Yes □ No If yes, please list date of injury _____

Is there an attorney involved in this case? □ Yes □ No If yes, name: _____

Preferred method of appointment reminders: □ Phone call to home □ Phone call to cell □ Text □ Email

Referring Doctor_____ Phone #_____

Primary Care Doctor_____ Phone #_____

INSURANCE POLICY INFORMATION

Primary Insurance Company _____ ID_____ Plan/Group_____

Policyholder's Name: Last_____ First_____ MI_____

Policyholder's DOB: _____ Policyholder's Relationship to Patient _____

Address of Policyholder (if different than above)

Street_____ City_____ State_____ Zip_____

Is the patient covered by additional insurance? □ Yes □ No

Secondary Insurance Company_____ ID_____ Plan/Group_____

Policyholder's Name: Last_____ First_____ MI_____

Policyholder's DOB: _____ Policyholder's Relationship to Patient _____

CONSENT TO TREATMENT (& Consent to Treatment of Minor Patient)

I, the undersigned, do hereby agree and give consent for High Plains Physical Therapy & Aquatic Therapy Center to administer medical care and treatment to me (or to my minor child) that is deemed necessary and proper in the treatment my (or my minor child's) physical and mental condition.

_____ _____

Patient Signature/Parent/Guardian Signature (if patient is minor) Date

MEDICAL HISTORY

PAIN/INJURY/SURGERY

Current Area(s) of Pain/Injury _____

Have you had Surgery related to your pain or injury? □ Yes □ No

If yes, date of surgery? _____ Surgeon_____

DIAGNOSTIC TESTS

Please check any tests or procedures that have been done for your **current** condition.

□ X-rays □ MRI □ CT Scan □ Bone Scan □ Bone density □ Ultrasound

MEDICAL HISTORY

Are you currently experiencing, or have you ever had any of the following conditions? Check all that apply.

□ Diabetes
□ Chest Pain/Angina
□ High Blood Pressure
□ Heart Disease
□ Heart Attack
□ Heart Palpitations
□ Nervous Disorders
□ Pacemaker
□ Chronic Headaches
□ Numbness in Toes
□ Allergies to Heat
□ Poor tolerance to Cold
□ Asthma/Respiratory Problems
□ Metal Implants
□ Osteoporosis
□ Neck Pain
□ Pins & Needles in Legs
□ Neck Stiffness
□ Numbness in hands/fingers
□ Bowel Abnormalities
□ Bladder Abnormalities
□ Urine leakage
□ Kidney Problems
□ Liver/Gallbladder Problems
□ Ringing in your ears
□ Lightheadedness
□ Low Back Pain
□ TMJ
□ Hernia
□ Cancer
□ Allergies
□ Seizures
□ Sleeping Problems
□ Heavy Head
□ Irritability
□ Stroke/CVA
□ Nausea/Vomiting
□ Shortness of Breath
□ Joint Pain
□ Dizziness/Fainting
□ Previous Surgeries

Are you currently pregnant? □Yes □ No

Please list any medications you are currently taking (or provide our office staff with a list of medications to attach to your permanent medical record): _____

_____

Allergies to Medications? □ Yes □ No Description _____

Do you participate in sports, exercise programs or activities on a regular basis? □ Yes □ No

If yes, what sports/programs/activities? _____

PATIENT AUTHORIZATION & FINANCIAL POLICY

As a courtesy, High Plains Physical Therapy (HPPT) will verify your insurance benefits; however, it is ultimately your responsibility to be aware of your specific coverage. We will also bill your insurer on your behalf. If your insurer designates that a copayment, deductible and/or co-insurance is your responsibility, we are obligated to collect it. The ultimate payment responsibility is yours and you will be billed for any balance not paid by your insurance.

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/FINANCIAL RESPONSBILITY
I authorize my insurer to pay benefits directly to HPPT. I authorize HPPT to release all information necessary to secure payment including documentation on the medical record which may include present or past history. I understand that I am financially responsible for all charges incurred by HPPT. Any portion of these charges not covered by my insurer must be paid by me. I further understand that copayments are due at the time of my HPPT visit and that payment of any deductibles and coinsurance are my responsibility as stated by my contract with my insurer.

HIPAA NOTICE OF PRIVACY PRACTICES (SEE SEPARATE NOTICE & ACKNOWLEDGMENT)
I understand that HPPT and its staff will make every effort to keep my protected health information confidential and private. My signature below acknowledges that I understand that HPPT may use and disclose my protected health information for treatment, for billing or to obtain payment, and for related health care reasons. I have been offered a copy of, read, or received HPPT's Notice of Privacy Practices and I may obtain a copy of the Privacy Notice at the HPPT office.

I have read and agree to the terms and information stated above.

_____ _____
Signature of Patient or Patient Representative if Patient is a Minor Date

AUTHORIZATION TO RELEASE INFORMATION

Please list any family members or others who you give permission to view the information found in your medical record or with whom you agree for us to discuss your physical therapy treatment with:

Name	Relationship to Patient	Expiration Date of Consent
_____	_____	_____
_____	_____	_____

CANCELLATION AND NO-SHOW POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit due to a seemingly "full" appointment schedule. For these reasons, if an appointment is not cancelled at least 24 hours in advance, you will be charged a $35.00 fee; this fee will not be covered by your insurance company and will be your responsibility.

By signing this form, you acknowledge you have read and understand the Cancellation and No-Show Policy of High Plains Physical Therapy and agree to give 24-hour notice in the event you cannot make a scheduled appointment and to be responsible for the $35.00 fee otherwise.

_____ _____
Patient Signature Date

HIPAA Notice of Privacy Practices Introduction (more detailed practices and acknowledgment on following pages)

Effective, April 14, 2003, we understand that information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us, which we need in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by **High Plains Physical Therapy Associates, Inc.**, whether made by your physical therapists or any employee of High Plains Physical Therapy Associates, Inc. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you and describe certain obligations we have regarding the use and disclosure of your health information.

We are required to:

- Make sure that health information that identifies you is kept private.
- Give you this Notice of our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the Notice that is currently in effect.

How we may use and disclose health information about you:

- For treatment
- For payment
- For health care operations
- As required by law
- To avert a serious threat to health and safety
- As required by the Military or Veterans and Workers Compensation
- Public health risk
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- Coroners, health examiners and funeral directors
- National Security and Intelligence activities
- Protective Service for the President and others

Your rights regarding Health Information about you:

- Right to inspect and copy
- Right to amend
- Right to accounting of disclosures
- Right to request restrictions
- Right to request confidential communications
- Right to a paper copy of this Notice.

Changes to this Notice:
We reserve the right to change this Notice. We will retain a copy of the current Notice in our facility.

Acknowledgement of Receipt of this Notice:
We will request that you sign a separate form acknowledging you have received a copy of this Notice. The acknowledgement will become part of your records.

High Plains Physical Therapy Associates, Inc
NOTICE OF PRIVACY PRACTICES

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.

Uses and Disclosures
There are a number of situations where we may use or disclose to other persons or entities your confidential medical information. Your confidential medical information is defined under federal law as "protected health information" ("PHI"). When we retain your confidential medical information on its computer system, it is called "electronic protected health information" ("ePHI"). This Notice applies to all PHI and ePHI related to your care that we have created or received. It also applies to any personal or general information we receive from patients, including information contained on driver's licenses. Certain uses and disclosures will require you to sign an Acknowledgement that you received our Notice of Privacy Practices, including treatment, payment and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures required by law or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

USE AND DISCLOSURE WITHOUT PATIENT ACKNOWLEDGEMENT OF THIS NOTICE
We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes:

Treatment: We will use your medical information to make decisions about the provision, coordination or management of your health care, including diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your medical information with another health care provider whom we need to consult with respect to your care.

Payment: We may need to use or disclose information in your medical record to obtain reimbursement from you or your health insurance plan, or another insurer for our services rendered to you. This may also include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for purposes of reimbursement. This information may also be used for billing, claims management and collection purposes together with related health care data processing through our system.

Operations: Your medical records may be used in our business planning and development operations, including improvement in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, medical review activities, and arranging for legal and auditing functions.

USE AND DISCLOSURE WITHOUT ACKNOWLEDGEMENT OR AUTHORIZATION

There are certain circumstances under which we may use or disclose your medical information without first obtaining your Acknowledgement or Authorization. Those circumstances generally involve public health and oversight activities, law enforcement activities, judicial and administrative proceedings and in the event of death. Specifically, we are required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases and HIV/AIDS status. We are also required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law enforcement officials information that you or another person are in immediate threat of danger to your health or safety as a result of violent activity. We must also provide medical record information when ordered by a court of law to do so.

AUTHORIZATION FOR USE OR DISCLOSURE

Except as outlined in the above sections, your medical information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental health treatment, drug and alcohol abuse, HIV/AIDS, or sexually transmitted diseases which may be contained in your medical records without your specific written consent and authorization. We likewise will not disclose your medical record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization. Your medical information will not be disclosed for marketing purposes or sold to any third party without your authorization.

Other uses and disclosures of your medical record information not covered by this Notice or the laws that apply to us will be made only with your written permission. If you provide us with permission to use or disclose information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to "take back" any disclosures that we have already made with your permission and that we are required to keep any records of the care that we provided to you.

ADDITIONAL USES AND DISCLOSURES

Advice of Appointment and Services: The Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may interest you. The following appointment reminders may be used by the Practice: a) postcard mailed to you at your address provided by you; and b) telephoning your home and leaving a message on your answering machine or with the individual answering the phone. c) a text message to a designated phone number

Individual Rights

You have certain rights with respect to your medical record information, as follows:

1. You may request that we restrict the uses and disclosures of your medical records information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with respect to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

2. You may also request a restriction on disclosure of protected health information to a health plan for purpose of payment or health care operations if you paid for the services out of your own pocket, in full. This does not apply to services that are covered by insurance. You are required to pay cash, in full, for the services before the restriction applies.

3. With respect to ePHI, we agree to give you your ePHI in the form and format requested by you, if it is readily producible in that form or format. If it is not readily producible in the form or format requested, we will give you a readable hard copy form. Any directive given to us by you to transmit ePHI must be done in writing by you, signed and clearly identify the designated person and location to send the ePHI. We will provide you access to your PHI or ePHI within thirty (30) days from the date of request.

4. You have the right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you will be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

5. You have the right to inspect, copy and request amendment to your medical records. Access to your medical records will not include psychotherapy notes

contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding or for which your access is otherwise restricted by law. We will charge a reasonable fee for providing a copy of your medical records, or a summary of those records, at your request, which includes the cost of copying, postage, or preparation of an explanation or summary of the information.

6. We may deny any request for amendment of your PHI or ePHI if the information was not created by us (unless the originator of the information is no longer available to act on your request); is not part of the designated record set maintained by us; is not part of the information to which you have a right of access; or is already accurate and complete, as determined by us. If we deny your request for an amendment, we will give you a written denial including the reasons for the denial and the right to submit a written statement disagreeing with the denial.

7. All requests for inspection, copying and/or amending information in your medical records must be made in writing and be addressed to "Privacy Officer" at our address. We will respond to your request in a timely fashion.

8. You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your medical records information except for disclosures required for treatment, payment and health care operations, disclosures that require an Authorization, disclosures incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any 12-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same 12-month period.

9. You have the right to obtain a paper copy of this notice if the notice was initially provided to you electronically, and to take one home with you if you wish.

10. All requests related to your rights herein must be made in writing and addressed to "Privacy Officer" at the address noted below.

11. You have the right to receive notification from us if any breach of your unsecured protected health information occurs.

Our Duties

We have the following duties with respect to the maintenance, use and disclosure of your medical records:

1. We are required by law to maintain the privacy of the protected health information in your medical records and to provide you with this Notice of its legal duties and privacy practices with respect to that information.

2. We are required to abide by the terms of this Notice currently in effect.

3. We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and medical records we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

Complaints

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe your privacy rights with respect to confidential information in your medical records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of a complaint to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints online at the government's website: http://www.hhs.gov/ocr/hipaa.

This Notice of Privacy Practices shall not be construed as a contract or legally binding agreement. Any non-compliance with any provision of this Notice shall not be construed as a breach of contract, breach of confidentiality, invasion of privacy, misappropriation of name or likeness, violation of any consumer protection law, negligence or violation of any state law. By signing the Acknowledgment of Receipt of this Notice, you agree that the sole legal recourse for our non-compliance with this Notice is to file a written complaint to the Secretary of the U.S. Department of Health and Human Services, and that no complaint or cause of action may be filed in any federal or state court for breach of contract, breach of confidentiality, invasion of privacy, misappropriation of name or likeness, violation of any consumer protection law, negligence or violation of any state law, or under any tort theory.

Contact Person

All questions concerning this Notice, or requests made pursuant to it, should be addressed to:

Katherine Young, Privacy Officer, at the following address:

614 East Boulevard
Rapid City, SD 57701

or E-mail: painfree@highplainspt.com

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

As part of my health care, **High Plains Physical Therapy Associates, Inc**. creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among **High Plains Physical Therapy Associates, Inc.**'s personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and medical information to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we billed for was performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for **High Plains Physical Therapy Associates, Inc.** that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that **High Plains Physical Therapy Associates, Inc.** may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand **High Plains Physical Therapy Associates, Inc**, for **Workman's Compensation Cases**, will release the minimum necessary PHI/ePHI to your employer, your worker's compensation insurance carrier, third party administrator, rehab nurse or nurse case manager unless otherwise restricted below.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that **High Plains Physical Therapy Associates, Inc.** is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of High Plains Physical Therapy Associates, Inc. and agree to the liability limitations explained therein.

_____ _____
Signature of patient or legal representative Date

_____
Relationship to Patient

_____
Printed name of patient

AUTHORIZATION & CONSENT TO TRANSMIT PROTECTED HEALTH INFORMATION & ELECTRONIC PROTECTED HEALTH INFORMATION VIA INTERNET/EMAIL

I, _____, expressly request, authorize, direct, permit and unequivocally consent to High Plains Physical Therapy transmitting my Protected Health Information ("PHI") and Electronic Protected Health Information ("ePHI") to me and/or other health care providers for coordination of care, via the unsecured Internet. I expressly and unequivocally acknowledge that High Plains Physical Therapy does not have the capability to respond to my electronic mail transmissions or to submit by PHI or ePHI to other healthcare providers through encrypted or otherwise secured Internet connections. I expressly and unequivocally waive any claims or rights with respect to transmission of ePHI or PHI via the unsecured Internet. I fully understand that third parties may attempt to or access, use and disclose PHI or ePHI transmitted by High Plains Physical Therapy pursuant electronic mail inquiries and transmissions. I fully understand the risks of transmitting unencrypted electronic mail containing ePHI and I am willing to accept those risks. I knowingly, intentionally and voluntarily waive all rights, claims and damages relating to the negligence, breach of confidentiality or other tort and all other legal claims that could be asserted against High Plains Physical Therapy or any of its employees., agents, members or otherwise as a result of any third person improperly accessing, using or disclosing my PHI or ePHI as a result of transmission via the unsecured Internet. I intend to be legally bound hereto.

_____	_____	_____
Signature of Patient or Legal Guardian/Representative	Relationship to Patient	Date