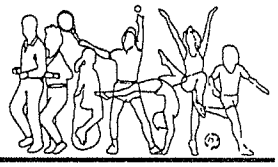
HANSEN PHYSICAL THERAPY

- Personal
- Professional
- Experienced Physical Therapy



50 E. Minnesota St. Ste. 2, Rapid City, SD 57701 • Phone (605) 342-3110 • Fax (605) 342-3120 • www.hansenphysicaltherapy.com

Patient Information

Last Name:	First Name:	Middle Name:
Street Address:	City, State & Zip	
E-mail Address:	Social Security Number:	
Home Phone:	Work Phone:	Cell Phone:
Date of Birth:	Gender: ☐ Male ☐ Female	
Patient Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partner ☐ Legally Separated		
Employer/School Name:	Phone:	
Address:	Job Description:	Are you a student?
How did you hear about us?		

Responsible Party

Person responsible for the bill (only if different than Patient): Last:	First:	M:
Date of Birth:	Social Security Number:	Phone:
Address of Person Responsible:	City, State & Zip:	
Employer of Person Responsible:	Relationship to Patient:	

Insurance Information

Primary Medical Insurance	Secondary Medical Insurance
Insurance Co. Name:	Insurance Co. Name:
Policy Holder's Name:	Policy Holder's Name:
Policy ID Number:	Policy ID Number:
Policy Holder's Date of Birth:	Policy Holder's Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
Policy Holder's Relationship to Patient:	Policy Holder's Relationship to Patient:

Physician

Referring Physician	Primary Care Physician
Referring Physician:	Primary Care Physician:
Clinic:	Clinic:

Injury or Pain

Date of Injury/Onset of pain:
What body part is affected (involved)?
Where were you when the injury pain occurred?

Work Comp.

Name of Insurance:	Date of Accident:	
Billing Address:	City, State & Zip:	
Phone Number:	Claim Number:	Adjuster's Name

Attorney

Attorney's Name:	Phone Number:
Address:	City, State & Zip

I hereby assign all medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Hansen Physical Therapy. I further authorize assignee to obtain my plan provisions under ERISA and to act as authorized representative on my behalf on insurance claims. This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I authorize the use of this signature on all my insurance and/or employee health benefits claim submission. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information, including medical record copies, necessary to secure payment and to complete disability forms presented to me. In response to any reasonable request of cooperation, I agree to cooperate with Hansen Physical Therapy. in any attempts by Hansen Physical Therapy to pursue such claim, choose action or right against my insurers and/or employees health care plan. Late fees will be applied at the rate of 1.5% per month (18% APR) on past due accounts. If any collections fees are added to your account upon nonpayment, you will be responsible for those charges.

Signature of Patient _____ Date _____

Authorization for the Use and Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996 Hansen Physical Therapy, Inc. may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures described herein. You may revoke this authorization at any time by signing and dating the revocation form and returning it to our office.

I _____,(print patient name or name of minor child) hereby authorize and request the use and disclosure of all the health information that pertains to me. I authorize and request Hansen Physical Therapy, Inc. to make these disclosures of my health information. I authorize and request the following persons to receive these disclosures of my health information and elect not to provide statement of purpose for the use of the disclosure to the following persons (please print):

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer be protected. I understand that this authorization will automatically expire on December 31, 2018, but that I may revoke this authorization at any time by signing the revocation form and returning it to Hansen Physical Therapy, Inc. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization. I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not.

I received a copy of Hansen Physical Therapy, Inc. Privacy Notice.

_____ _____
Signature of Patient Date
Or Parent of a Minor Child

Minor Consent Form

As the Parent/Guardian to _____ , a minor I am authorizing the following.
Please initial in the provided blanks to those that you are authorizing.

1. _____ I authorize _____ , a minor, to be seen **without** a parent or guardian present.
2. _____ I authorize _____ , a minor, to been seen and treated at Hansen Physical Therapy when accompanied only by the following adult, friend, child care provider etc.

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Signature of Parent or Guardian Date

Only complete this form if you wish to **revoke** the Authorization for Use and Disclosure of Protected Health Information or Minor Consent.

Patient Name	Patient Date of Birth
Signature of Patient or Parent or Guardian	Today's Date

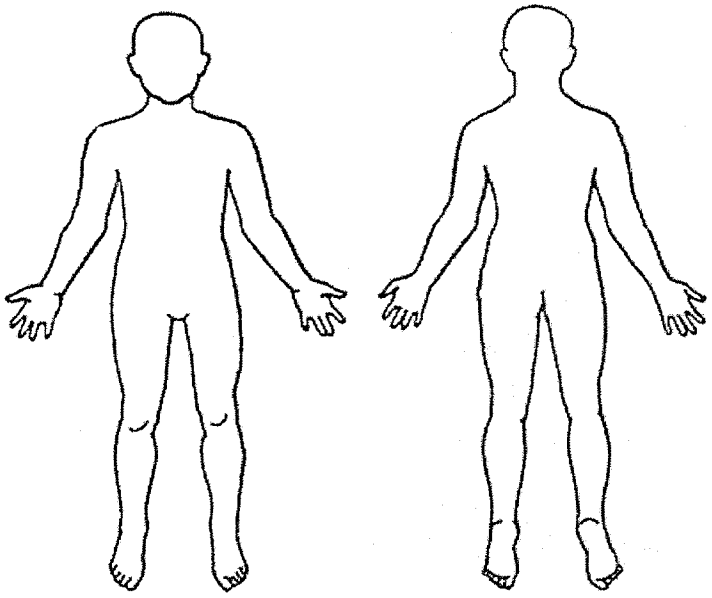
Health History

Patient Name:_____

Date:_____

Do you have, or have you had any of the following? If yes on any, please explain.

Heart Problems	No _____	Yes _____	_____
Pacemaker	No _____	Yes _____	_____
Metal Implants	No _____	Yes _____	_____
Cancer	No _____	Yes _____	_____
Stroke	No _____	Yes _____	_____
Diabetes	No _____	Yes _____	_____
High Blood Pressure	No _____	Yes _____	_____
Joint Pain	No _____	Yes _____	_____
Lung Problems	No _____	Yes _____	_____
Seizures	No _____	Yes _____	_____
Allergies	No _____	Yes _____	_____
Dizziness	No _____	Yes _____	_____
Other	No _____	Yes _____	_____



Please indicate on diagram where you experience pain.

My pain is **increased** by:_____

My pain is **decreased** by:_____

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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. The Health Information Portability & Accountability Act of 1996 (HIPPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPAA provides penalties for covered entities that misuse personal health information. As required by HIPPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: **treatment, payment, and health care operations.**

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. Any other uses and disclosures will be made only with your written authorization except in instances required by law. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. **You have the following rights** with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- **The right** to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- **The right** to reasonable requests to receive confidential communications of protected health information from us by alternative locations.
- **The right** to inspect and copy your protected health information.
- **The right** to amend your protected health information.
- **The right** to receive an accounting of disclosures of protected health information.
- **The right** to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post, and you may request a written copy of, a revised Notice of Privacy Practices from this office. If you feel that your privacy rights have been violated, you may file a written complaint at the address listed below. Under no circumstances will the fact that you have filed a complaint affect the services provided to you by Hansen Physical Therapy.

Ryan C. Hansen, DPT/Owner
Kami L. Palmer, DPT
Megan L. Mullanix, PTA

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