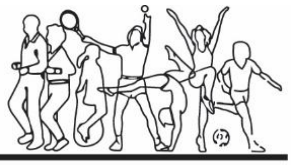
HANSEN PHYSICAL THERAPY

• 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:		Job Description:		Phone:	
	Address:			Are you a student?		
	How did you hear about us?					
	Emergency Contact:		Relationship:		Phone:	
Responsible Party	Person responsible for the bill (only if different than Patient): Last:			First:		
	Date of Birth:		Social Security Number:		Phone:	
	Address of Person Responsible:			City, State & Zip:		
	Employer of Person Responsible:			Relationship to Patient:		

	Primary Medical Insurance	**Secondary Medical Insurance**
Insurance Information	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:

Reminders	Would you like appointment reminders? ☐ Yes ☐ No
	If yes, please check how you would like to be contacted**:** ☐ Email ☐ Text *** Standard messaging rates apply**
	Cell phone carrier:
	☐ I consent to all communication, including but not limited to communication about my medical condition and advice from Physical Therapist by the following means: ☐ Email ☐ Text
	☐ I do not consent to any email or texting communication.

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 to act as authorized representative on my behalf on insurance claims. 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. This order will remain in effect until revoked by me in writing. 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.

_____ _____

Signature of Patient or Guardian 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 may not use or disclose your health information to anyone without your authorization, except as provided in our Notice of Privacy Practice. Your signature on the following section indicates that you are giving permission for the uses and disclosures described herein. 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 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

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, 2023, but that I may revoke this authorization at any time by signing the revocation form and returning it to Hansen Physical Therapy. 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.

_____ _____
Signature of Patient or Guardian Date

Communication Consent: Patients/Clients frequently request that we communicate with them by email or text. Hansen Physical Therapy respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur.

Since email and texting are insecure as a method of communication, we will only communicate with you by email or text with your written consent at the email address or phone number you provide to us.

Further examples of communication include: exercises, imaging reports, diagnostic's studies, response to treatment and follow-up care. We will not send out personally indefinable information such as Social Security number, date of birth, insurance information or personal address.

When you consent to communicating with us by email or text you are consenting to email and texting communications that may not be encrypted. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information.

Hansen Physical Therapy will not be responsible for any privacy or security breaches that may occur through email or text communications that you have consented to. You may choose to limit the type of email or text communication to decrease your risk of exposing your protected health information to unauthorized persons.

Payment for Service Is Expected at Each Visit*: This includes deductibles, co-insurance, co-payments, and treatment or supplies not covered by insurance. The following methods of payment are accepted: cash, checks, or credit. This section does not apply to workers compensation patients. If your account becomes delinquent, collection proceedings will occur, and you will be 100% liable for any collection fees, reasonable attorneys' fees, and court costs incurred by the Hansen Physical Therapy to collect said fees from the responsible party.

Cancellation Policy *: If it is necessary to cancel an appointment, please call our office 24 hours in advance during business hours to cancel. If you feel ill, wary of road conditions or an emergency should arise please contact us as soon as possible. Our policy is to charge a cancellation fee of $40.00 for **three consecutive missed appointments** as a no-show fee. Hansen Physical Therapy wants you to get the maximum results from treatment and this means attending your appointments on a regular basis.

Notice of Privacy Practices*: Your signature below indicates that you have been made aware of our privacy practice. A copy will be provided to you upon your request. In addition, the undersigned patient or responsible party acknowledges that they have read and agrees to the information provided.

I have read and understand the above polices.

***See our "Appointment & Payment Agreement Form "and "Notice of Privacy Practices" for more information**

_____ _____

Signature of Patient or Guardian Date

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 and treated 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, childcare provider etc.

_____ _____

Name Relationship

_____ _____

Name Relationship

_____ _____

Signature of Parent or Guardian Date