Patient Registration Form

CAROLINA BEACH CBPT PHYSICAL THERAPY

Patient Information *(Please print)*

Patient's Name Last:_____ First:_____ Middle Initial:_____

Date of Birth: (MM/DD/YYYY)____/_____/_____ Sex: ❑ Male ❑ Female ❑ _____

Home Phone Number: (_____)_____ Cell Phone Number: (_____)_____

Work Phone Number: (_____)_____ E-mail address: _____

Appointment reminder preference: ☐ E-mail ☐ Text ☐ Phone call. If text/phone call, to which number? (_____)_____

Are your injuries a work related incident? ❑ Yes ❑ No Date of Injury____/_____/_____

Are your injuries related to a motor vehicle accident? ❑ Yes ❑ No Date of Injury____/_____/_____

In Case of Emergency

Name of emergency contact: _____

Relationship to Patient:_____ Telephone number (____)_____

How Did You Hear About Us? We'd Love to Know!

❑ Online Search

❑ Social Media

❑ Newspaper/Print Ad

❑ Online Ad (Facebook, etc.)

❑ Other: _____

❑ Referral from friend or family member:

Name : _____

Medical History Form

CAROLINA BEACH CBPT PHYSICAL THERAPY

PERSONAL INFORMATION

Name: _____ **Date:** _____

Gender: _____ **D.O.B.:** _____

HISTORY

Exercise Frequency: _____ **Exercise Type:** _____

Do you smoke?: Y N **Smoked in the past:** Y N **How Often:** _____

Are you pregnant? Y N **Do you have a pacemaker?** Y N

Allergies: _____

Current Medications: _____

Have you had any of the following? (Circle all that apply):

Arteriosclerosis	Circulation Problems	Hemophilia	Pneumonia
Arthritis	Drug Use	Heart Problems	Stroke/TIA
Asthma	Depression	High Blood Pressure	STD
Blood Clots	Diabetes	Lung Problems	Tuberculosis
Bone Infection	Epilepsy	Liver Problems	Urinary Infection
Cancer	Eye Infection	Low Blood Pressure	
COPD	Heart Attack	Multiple Sclerosis	

Other problems/diagnoses: _____

Other surgeries: _____

_____ _____

Signature of Patient or Parent Date

CAROLINA BEACH CBPT PHYSICAL THERAPY

CONSENT TO THERAPY

I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist and support staff employed by Carolina Beach Physical Therapy, LLC. (CBPT). I understand that the physical therapist will explain the purpose and procedures they will perform. I will also be informed as to the expected benefits or potential complications as a result of participation.

Initial _____

1) I realize I have the right to refuse any treatment or procedures to the extent permitted by law. I understand the delivery of healthcare is not an exact science, so no guarantees or warranties can be made to me regarding the result of any treatments at this facility. I understand the information from medical records kept by this facility may be used for educational, administrative and/or facility approved purposes and my personal identity will not be revealed.

   Initial _____

2) I authorize payment of medical benefits to Carolina Beach Physical Therapy, LLC. for services rendered. I understand that CBPT will make reasonable effort to collect insurance proceeds by submitting billing information for processing. Completion of such forms and/or the acceptance of assignment of insurance benefits does not relieve the undersigned of the obligation to pay the amount owed for physical therapy.

   Initial _____

3) I understand that copayments/co-insurances are due at the time of service. I understand that CBPT does have a payment plan if you need to extend your payments over a longer period of time.

   Initial _____

4) I understand that CBPT has a **STRICT FRAGRANCE POLICY.** Please refrain from wearing perfume, cologne, or lotion to therapy sessions. We have patients and staff who suffer from asthma and respiratory problems and are highly sensitive to strong odors and fragrances.

   Initial _____

5) I authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service. I am responsible for any services not covered by this authorization. I have read and fully understand the Patient Financial Responsibilities Form.

   Initial _____

6) Worker's Compensation-I hereby authorize my case manager to receive my records related to my work injury.

   Initial _____

7) I understand that my doctor will automatically receive a copy of my records at no charge; and that if I or anyone else indicated above request and obtain a copy of my medical records, I will be responsible for a 25¢ fee per page of records provided

   Initial _____

Acknowledgment of the "Notice of Privacy Practices" release of medical information request.

I have been given the opportunity to review Carolina Beach Physical Therapy's "Notice of Privacy Practices". This document contains a description of the uses and disclosures of my protected healthcare information and my rights regarding such information. CBPT displays the "Notice of Privacy Practices" in its clinic reception area. I understand that CBPT has the right to change its "Notice of Privacy Practices" and that if changes are made, a revised copy of the notice will be posted in the reception area. I also understand that I have if I have any questions or wish to receive copies of the current "Notice of Privacy Practices", I may request that document from the front desk or access it from the CBPT website. I permit a copy of this form to be used in lieu of the original.

Initial _____

I authorize CBPT, LLC (CBPT) to obtain a release health information from/to the following:

_____
Name of person or Name of facility

_____
Name of person or Name of facility

_____
Name of person or Name of facility

If you are the representative for the patient, check the scope of your authority to act on the patient's behalf:

❑ Power of Attorney ❑ Guardian ❑ Parent ❑ Other

I have read and fully understand the above general consent form. Any questions I have have also been answered to my satisfaction. By signing this form I am acknowledging my understanding of the "notice of privacy practices" and authorizing persons or institutions listed on the information release to receive or not receive my health information.

_____ _____
Signature of Patient or Parent Date

CAROLINA BEACH CBPT PHYSICAL THERAPY

1300 Bridge Barrier Rd.
Building 3
Carolina Beach, NC 28428

910.636.3574
910.636.3576 (fax)

CarolinaBeachPT.com

Patient Privacy Notice

Your information. Your rights. Our responsibilities.

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.***

Your rights

See page 2 for more information on these rights and how to exercise them.

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your choices

See page 3 for more information on these choices and how to exercise them.

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Market our services
- Raise funds

Our uses and disclosures

See pages 3 and 4 for more information on these uses and disclosures.

You have some choices in the way that we use and share information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions rights

Your rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our uses and disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

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Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date of Notice 09/1/17

This Notice of Privacy Practices applies to the following organization:

Carolina Beach Physical Therapy