



Patient Registration Form

LAST NAME		FIRST	MI	DATE OF BIRTH / /	AGE	SOCIAL SECURITY #	
HOME ADDRESS			CITY		STATE	ZIP CODE	
HOME PHONE			CELL PHONE		WORK PHONE		
EMPLOYMENT STATUS EMPLOYED () FULL TIME STUDENT () PART TIME STUDENT () N/A ()			MALE () FEMALE ()		MARITAL STATUS SINGLE () MARRIED () OTHER ()		
EMPLOYER NAME/SCHOOL NAME				TITLE/POSITION			
EMERGENCY CONTACT, LEGAL GUARDIAN, INSURED INFORMATION							
LAST NAME		FIRST		MI	HOME PHONE		
ADDRESS				STATE	ZIP CODE		
EMPLOYER				WORK PHONE			
REFERRING PHYSICIAN INFORMATION							
LAST NAME		FIRST		NPI#		UPIN#	
ADDRESS			TELEPHONE #			FAX #	
REFERRING DIAGNOSIS:		ACCIDENT? INSIDIOUS? POST SURGICAL?			ONSET DATE:		
PRIMARY INSURANCE COMPANY INFORMATION							
PRIMARY INSURANCE COMPANY NAME		EFFECTIVE DATE		IDENTIFICATION #		GROUP #	
ADDRESS		CITY		STATE	ZIP CODE		PHONE
POLICYHOLDER (if other than patient)		SOCIAL SECURITY #			RELATIONSHIP		DATE OF BIRTH / /
(CIRCLE ONE) SCRIPT / REFERRAL		AUTH #		AUTH DATE		EXP. DATE	
COPAY / COINSURANCE		DEDUCTION AMT.		MET () YES () NO		MAX # VISITS	
ADJ / CASEWORKER		TELEPHONE #			FAX #		
SECONDARY INSURANCE COMPANY INFORMATION							
SECONDARY INSURANCE COMPANY NAME		EFFECTIVE DATE		IDENTIFICATION #		GROUP #	
ADDRESS		CITY		STATE	ZIP CODE		PHONE #
POLICYHOLDER (if other than patient)		SOCIAL SECURITY #			RELATIONSHIP		DATE OF BIRTH / /
(CIRCLE ONE) SCRIPT / REFERRAL		AUTH #		AUTH DATE		EXP. DATE	
COPAY / COINSURANCE /		DEDUC. AMT.		MET () YES () NO		MAX # VISITS	



HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M	<input type="checkbox"/> F	DOB:	
Previous or referring doctor:	Referring Diagnosis:			
Occupation/ Student:	Living Status:		<input type="checkbox"/> Alone <input type="checkbox"/> Spouse <input type="checkbox"/> Other	

PERSONAL HEALTH HISTORY

Chief complaint you are being seen for:	Onset Date:
Is condition due to injury/accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please describe:	
Attorney involvement? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list contact information: Name:	
	Phone:
Does this condition effect your daily activities/ work responsibilities? <input type="checkbox"/> Yes <input type="checkbox"/> No	First date missed from work:
Have you had prior treatment for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please describe:

Recent Surgeries	Current Medications

Do you have any allergies? Yes No If yes, please list:

Have you had any unexpected weight lose or gain greater than 10 pounds in the past 3 months? Yes No

Do you have any of the following medical conditions? (Please check all that apply)

Hearing Problems Pacemaker Lymphedema Diabetes Stroke Metal Implants Broken Bones
 Vascular Problems Pregnant Pneumonia Seizures Osteoporosis Arthritis Respiratory Problems
 High Blood Pressure Cancer: _____ Other: _____

What are your goals for therapy?

In case of emergency please contact: Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

** *To be completed by therapist* **

Therapist:	Date:
Precautions for treatment	
Other pertinent information	

Notice of Patient Information Practices

OUR LEGAL DUTY

Bresee Outpatient Physical Therapy, P.A. is required by law to protect the privacy of your personal and health information, provide notice about our information management practices, and follow the information protocols described below.

USES AND DISCLOSURES FO HEALTH INFORMATION

Bresee Outpatient Physical Therapy, P.A. uses your personal information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and assessing the quality of care we are proud to provide. We use your personal information to contact you to arrange an appointment with us and to properly bill your insurance carrier for the services we provide you with. In addition, we may, from time to time, disclose your health information without prior authorization for public health purposes, auditing tracking, and research studies. In any other situation, Bresee Outpatient Physical Therapy, P.A. will obtain your written permission and authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to cease future disclosures at any time. If and when any changes are made in our privacy and confidentiality policies, a new Notice of Information Practices will be posted in the same area for public view. You may request a copy of our Notice of Information Practices at any time. Our HIPAA Compliance Officer is Diana Robison. She can be reached at the office by calling (662) 842-2100

PATIENTS INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct inaccurate or incomplete information in your records. You also have the right to request a list of instances where we disclosed your personal health information for reasons other than for treatment, payment, or other related administrative purposes except when specifically authorized by you, when required by law, or in an emergency. Bresee Outpatient Physical Therapy, P.A. will consider all such requests on a case-by-case basis. The company is not legally required to accept the requests.

CONCERNS AND COMPLAINTS

If you are concerned that Bresee Outpatient Physical Therapy, P.A. may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our HIPAA Compliance Officer, Diana Robison, at the office address and phone number listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

Bresee Outpatient Physical Therapy, P.A.
HIPAA Compliance Office
Attention: Diana Robison
238 Third Avenue
P.O. Box 456
Sherman, MS 38869
(662)842-2100



Consent for Treatment

I, the undersigned, a patient at Bresee Outpatient Physical Therapy, P.A., do hereby authorize Mark Bresee, P.T., and whoever he may designate as his assistant to administer treatment as is necessary. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that as a courtesy Bresee Outpatient Physical Therapy will prepare insurance forms and bill my insurance company directly. I hereby request assignment of payment of all insurance benefits to Bresee Outpatient Physical Therapy, P.A. I am ultimately responsible for payments of all services rendered, unless other wise provided by law.

Deductibles/Percentage pays and/or Co-Payments

Co-payments are to be paid at time of service, unless prior arrangements have been made with the Office Manager. Deductible and percentage payment amounts will be billed at the time the payment from your insurance company is received. Payment is due within 30 days of the date on the invoice. Patients are to keep payments current.

Cancellation/No-Show Policy

I understand that cancellations should be made within 24 hours prior to their scheduled time, unless extenuating circumstances prevent otherwise. A \$25.00 fee may be enforced for no shows or late cancellations. By signing below you are agreeing to all the above terms and conditions. Additionally I confirm that I have received a copy of Bresee Outpatient Physical Therapy's Notice of Privacy Practices.

Patient or Legal Guardian's Signature

Date



Release of Records Form

Date: _____

By my signature below, I hereby authorize release of my medical records to Bresee Outpatient Physical Therapy, P.A.

Patient Name: _____

Date of Birth: _____

Records related to: _____

Patient's Signature: _____

Please fax records to:

Bresee Outpatient Physical Therapy, P.A.
Fax Number (662)842-2105