

PATIENT REGISTRATION-PINAMONTI PHYSICAL THERAPY

NAME: (last) _____ (first) _____ (m) _____

ADDRESS: _____

City: _____ State: _____ Zip _____

HOME PHONE: _____ CELL: _____ E-MAIL _____

DATE OF BIRTH: _____ SEX: _____ MARITAL STATUS: _____

SOCIAL SECURITY #: _____

PLACE OF EMPLOYMENT: _____

WORK PHONE: _____

SPOUSE'S NAME: _____ SOCIAL SECURITY# _____

SPOUSE'S EMPLOYER: _____

PHONE #: _____

EMERGENCY CONTACT: _____ PHONE: _____

PRIMARY INSURANCE NAME: _____ POLICY # _____

SECONDARY INSURANCE NAME: _____ POLICY # _____

INSURED NAME (IF NOT SELF): _____

REFERRING PHYSICIAN NAME: _____

Date of Onset of illness or injury: _____

Physical Therapy is for treatment of (circle): post-op back/neck work injury other
Auto accident/claim# _____

How did you hear about Pinamonti Physical Therapy? (circle)

Doctor Friend/Relative Phone book

Managed care plan Employer

Other: _____

Please indicate method of payment (deductible, copay, non-covered services):

CASH _____ CHECK _____ VISA/MASTERCARD _____

SIGNATURE: _____ DATE: _____

PINAMONTI PHYSICAL THERAPY

MEDICAL HISTORY QUESTIONNAIRE

CHECK ALL THAT APPLY

NO KNOWN MEDICAL CONDITIONS

- Abnormal EKG
- Adrenal Insufficiency
- Angina
- Asthma
- Bleeding Disorder
- Cardiac Dysrhythmia
- Cataracts
- Clotting Disorder
- Coronary Bypass Graft
- Dementia/Alzheimer's
- Diabetes Insulin Dependent
- Eye Surgery
- Glaucoma

- Hemolytic Anemia
- Hypertension
- Hypoglycemia
- Laryngectomy
- Leukemia
- Lymphomas
- Memory Impaired
- Myasthenia Gravis
- Pacemaker
- Renal Failure
- Seizure Disorder
- Stroke
- Vision Impaired
- Hemodialysis

Other _____

ALLERGIES

MEDICATIONS

SIGNATURE _____

DATE _____

PINAMONTI PHYSICAL THERAPY, PA

BILLING POLICY, RELEASE AND AUTHORIZATION

I authorize Pinamonti Physical Therapy, PA, to bill my insurance company directly for the covered portion of charges, and I authorize payment of medical benefits directly to Pinamonti Physical Therapy. I authorize Pinamonti Physical Therapy to release medical or other information necessary to process this claim. ***I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, my co-insurance or co-payment, and any charges not reimbursed by my insurance carrier.*** I understand that some insurance companies require medical or administrative pre-authorization for treatment, or have reimbursement limits on physical therapy treatment. I understand I am responsible for knowing and meeting the requirement of my insurance plan.

I will notify Pinamonti Physical Therapy of any cancellation I may have to make.

I understand that if I do not show up for an appointment, and do not notify Pinamonti Physical Therapy before the set appointment, there will be a \$20 charge that will be my responsibility and will not be billed to insurance.

I understand that if the patient portion is not paid within 90 days of being billed, there will be an additional finance charge of 18% added.

I understand that if my account is sent to our collection agency, there will be an additional 35% charge added to the amount owed.

Signature _____ Date _____

PINAMONTI PHYSICAL THERAPY
FINANCIAL AGREEMENT

Date: _____

Patient Name: _____

I have been notified of my insurance benefits, including co-pay and deductibles that have not been met. I agree to pay Pinamonti Physical Therapy _____, per week, until the said **deductible** has been met according to my insurance.

If the balance, after therapy has been discontinued and all claims have been filed with my insurance, is **\$500 or less**, I have agreed to pay **three** equal monthly payments until my account is paid in full.

If the balance, after therapy has been discontinued and all claims have been filed with my insurance, is **\$500 or more**, I have agreed to pay **six** equal monthly payments until my account is paid in full. **At this point, finance charges of 18% will be added.**

If there is no insurance involved and this is a private pay situation, I agree to pay for each visit in full at time of appointment.

I understand if I fail to make these payments, as agreed upon, Pinamonti Physical Therapy will send my account to a collection agency for any and all expenses that were incurred while attending therapy at their facility.

Method of payment:

CASH

CHECK

CREDIT CARD

Signature

Date



Pinamonti Physical Therapy Brian W. Pinamonti

1014 Mt. Carmel Place Pittsburg, KS 66762

620-235-1500

Fax: 620-235-1508

brian@pinamontipt.com

PRIVACY NOTICE

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 protected health information (i.e., individually identifiable information, such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers, and demographic data) may be used or disclosed by us in one or more of the following respects:

- _ To other health care providers (i.e., your physician, orthopedic surgeon etc.) in connection with our rendering physical therapy treatment to you (i.e., to determine the appropriate plan of care, treatment etc.);
- _ To third party payors or spouses (i.e., insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account (i.e., to determine benefits, dates of payment, etc.);
- _ To certifying, licensing and accrediting bodies (i.e., the Kansas State Board of Healing Arts, etc.) in connection with obtaining certification, licensure or accreditation;
- _ Internally, to all staff members who have any role in your treatment;
- _ To other patients and third parties who may see or overhear incidental disclosures about your treatment, scheduling, etc.;
- _ To your family and close friends involved in your treatment; and/or,
- _ We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- _ We may mail appointment reminders in postcard form, leave messages about appointments on answering machines, which may be read or overheard by others.
- _ We may use or disclose your health information when we are required to do so by law.
- _ We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety

Any other uses or disclosures of your protected health information will be made only after obtaining your written authorization, which you have the right to revoke.

Under the new privacy rules, you have the right to:

- Request restrictions on the use and disclosure of your protected health information;
- Request confidential communication of your protected health information;
- Inspect and obtain copies of your protected health information through asking us;
- Amend or modify your protected health information in certain circumstances;
- Receive an accounting of certain disclosures made by us of your protected health information; and,
- You may, without risk of retaliation, file a complaint as to any violation by us of your privacy rights with us (by submitting inquiries to our Privacy Contact Person at our office address) or the United States Secretary of Health and Human Services (which must be filed within 180 days of the violation).

We have the following duties under the privacy rules:

- By law, to maintain the privacy of protected health information and to provide you with this notice setting forth our legal duties and privacy practices with respect to such information;
- To abide by the terms of our Privacy Notice that is currently in effect;
- To advise you of our right to change the terms of this Privacy Notice and to make the new notice provisions effective for all protected health information maintained by us, and that if we do so, we will provide you with a copy of the revised Privacy Notice.

Please note that we are not obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information;
- Amend your protected health information if, for example, it is accurate and complete; or,
- Provide an atmosphere that is totally free of the possibility that your protected health information may be incidentally overheard by other patients and third parties.

This privacy notice is effective as of the date of your signature. If you have any questions about the information in this Notice, please ask for our Privacy Contact Person or direct your questions to this person at our office address. Thank you.

PATIENT ACKNOWLEDGMENT

You may refuse to Sign This Acknowledgement

I hereby acknowledge that I have received and reviewed a copy of this Privacy Notice.

Patient or Guardian

Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other