RYAN PHYSICAL THERAPY ASSOCIATES

PATIENT INFORMATION SHEET

***Copays due at time of visit.**

PATIENT NAME: (MR. MRS. MISS) _____
(LAST) (FIRST) (MIDDLE NAME)

DATE OF BIRTH: _____ SS#: _____

ADDRESS:_____
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE #: _____ WORK PHONE #: _____

EMERGENCY CONTACT: _____ PHONE#: _____

REFERRING PHYSICIAN: _____

ADDRESS:_____
(STREET) (CITY) (STATE) (ZIP)

OFFICE PHONE #: _____ FAX #:_____

DATE OF INJURY OR ONSET OF SYMPTOMS: _____

DIAGNOSIS/CHIEF COMPLAINT: _____

IMPORTANT!

FOR YOUR CONVENIENCE ALL BILLING INQUIRIES NEED TO BE DIRECTED TO TJ ROCK ACCOUNTING AND MANAGEMENT SYSTEMS AT THE FOLLOWING NUMBERS 301-831-4352 (OFFICE) OR 877-942-6138(TOLL FREE)

IN ORDER FOR OUR BILLING OFFICE TO SUBMIT CLAIMS EFFECTIVELY, WE WILL NEED ALL NECESSARY PAPERWORK INCLUDING REFERRALS/DOCTORS ORDERS AND COPY OF INSURANCE CARDS. THIS IS THE PATIENT'S RESPONSIBILITY. ALSO, THE INSURANCE INFORMATION MUST BE FILLED OUT ON THE *SECOND PAGE* OF THIS FORM. IF YOU CHOOSE TO SUBMIT BILLS YOURSELF, PAYMENT WILL BE EXPECTED AFTER EACH TREATMENT SESSION UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE INITIALLY.

PLEASE NOTE: 24-HOUR NOTICE IS REQUIRED FROM ALL PATIENTS FOR ANY CANCELLATIONS. IF 24-HOUR NOTICE IS NOT GIVEN OR AN APPOINTMENT IS MISSED, A $15 CHARGE WILL BE ASSESSED. **REGARDING SPECIAL CIRCUMSTANCES OR EMERGENCIES, EXCEPTIONS MAY BE MADE AT THE DISCRETION OF THE THERAPIST.

**(Complete Page 2)

PRIMARY (PERSONAL) INSURANCE CARRIER: _____

ADDRESS:

_____

PHONE #:

_____

POLICY ID #: _____ **GROUP #:** _____

POLICYHOLDER NAME: _____ **DOB:** _____ **SS#:**_____

ADDRESS:

_____

****EMPLOYER:**

_____

****EMPLOYER ADDRESS:**

_____

****EMPLOYER PHONE #:**

_____

SECONDARY (PERSONAL) INSURANCE CARRIER:

_____

ADDRESS:

_____

PHONE #:
_____

POLICY ID#: _____ **GROUP #:** _____

POLICYHOLDER NAME: _____ **DOB:** _____ **SS#:** _____

ADDRESS:
_____

****EMPLOYER:**
_____

****EMPLOYER ADDRESS:** _____
_____

****EMPLOYER PHONE#:**
_____

WORKERS COMP/AUTO ACCIDENT CARRIER (CIRCLE ONE)
CARRIER:
_____

ADDRESS:
_____

CONTACT PERSON: _____ **PHONE #:** _____ **FAX#:** _____

CLAIM #: _____ **DATE OF INJURY/ACCIDENT :** _____

****EMPLOYER:**
_____

****EMPLOYER ADDRESS:**
_____

****EMPLOYER PHONE #:**
_____

ATTORNEY: _____ **YES** _____ **NO** **(IF YES) NAME:**
_____

ATTORNEY ADDRESS:
_____

ATTORNEY PHONE#: _____ **FAX#:** _____

IMPORTANT!

I AUTHORIZE PAYMENT TO RYAN PHYSICAL THERAPY ASSOCIATES FOR SERVICES PROVIDED. PLEASE ACCEPT A PHOTOCOPY OF MY SIGNATURE AS THE ORIGINAL, WHICH IS ON FILE. I AM AWARE THAT ANY CHARGES NOT COVERED BY MY INSURANCE POLICY ARE MY RESPONSIBILITY. I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION FOR THE PROCESSING OF MY CLAIMS.

_____ _____
PATIENT SIGNATURE **DATE**

HIPAA PRIVACY NOTICE

RYAN PHYSICAL THERAPY ASSOCIATES
1190 MOUNT AETNA ROAD
HAGERSTOWN, MARYLAND 21740
301-797-4572

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.

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) TO CARRY OUT TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS (TPO) AND FOR OTHER PURPOSES THAT ARE PERMITTED OR REQUIRED BY LAW. IT ALSO DESCRIBES YOUR RIGHTS TO ACCESS AND CONTROL YOUR PROTECTED HEALTH INFORMATION. "PROTECTED HEALTH INFORMATION" IS INFORMATION ABOUT YOU, INCLUDING DEMOGRAPHIC INFORMATION, THAT MAY IDENTIFY YOU AND THAT RELATES TO YOUR PAST, PRESENT OR FUTURE PHYSICAL OR MENTAL HEALTH OR CONDITION AND RELATED HEALTH CARE SERVICES.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION
YOUR PROTECTED HEALTH INFORMATION MAY BE USED AND DISCLOSED BY YOUR THERAPIST, OUR OFFICE STAFF AND OTHERS OUTSIDE OF OUR OFFICE THAT ARE INVOLVED IN YOUR CARE AND TREATMENT FOR THE PURPOSE OF PROVIDING HEALTH CARE SERVICES TO YOU, TO PAY YOUR HEALTH CARE BILLS, TO SUPPORT THE OPERATION OF THE THERAPIST'S PRACTICE, AND ANY OTHER USE REQUIRED BY LAW.

TREATMENT: WE WILL USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO PROVIDE, COORDINATE, OR MANAGE YOUR HEALTH CARE AND ANY RELATED SERVICES. THIS INCLUDES THE COORDINATION OR MANAGEMENT OF YOUR HEALTH CARE WITH A THIRD PARTY. FOR EXAMPLE, WE WOULD DISCLOSE YOUR PROTECTED HEALTH INFORMATION, AS NECESSARY, TO A HOME HEALATH AGENCY THAT PROVIDES CARE TO YOU. FOR EXAMPLE, YOUR PROTECTED HEALTH INFORMATION MAY BE PROVIDED TO A PHYSICIAN TO WHOM YOU HAVE BEEN REFERRED TO ENSURE THAT THE PHYSICIAN HAS THE NECESSARY INFORMATION TO DIAGNOSE OR TREAT YOU.

PAYMENT: YOUR PROTECTED HEALTH INFORMATION WILL BE USED, AS NEEDED, TO OBTAIN PAYMENT FOR YOUR HEALTH CARE SERVICES. FOR EXAMPLE, YOUR RELEVANT PROTECTED HEALTH INFORMATION MAY BE DISCLOSED TO THE HEALTH PLAN IN ORDER TO OBTAIN APPROVAL FOR CONTINUED TREATMENT.

HEALTH CARE OPERATIONS: WE MAY USE OR DISCLOSE, AS NEEDED, YOUR PROTECTED HEALTH INFORMATION IN ORDER TO SUPPORT THE BUSINESS ACTIVITIES OF YOUR THERAPIST'S PRACTICE. THESE ACTIVITIES INCLUDE, BUT ARE NOT LIMITED TO, QUALITY ASSESSMENT ACTIVITIES, EMPLOYEE REVIEW ACTIVITIES, TRAINING MEDICAL STUDENTS, LICENSING, AND CONDUCTING OR ARRANGING FOR OTHER BUSINESS ACTIVITIES. FOR EXAMPLE, WE MAY DISCLOSE YOUR PROTECTED HEALTH INFORMATION TO MEDICAL SCHOOL STUDENTS THAT SEE PATIENTS IN OUR OFFICE. IN ADDITION, WE MAY USE A SIGN-IN SHEET AT THE REGISTRATION DESK WHERE YOU WILL BE ASKED TO SIGN YOUR NAME AND INDICATE YOUR PHYSICIAN. WE MAY ALSO CALL YOU BY NAME IN THE WAITING ROOM WHEN YOUR THERAPIST IS READY TO SEE YOU. WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION, AS NECESSARY, TO CONTACT YOU TO REMIND YOU OF YOUR APPOINTMENT.

WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION IN THE FOLLOWING SITUATIONS WITHOUT YOUR AUTHORIZATION. THESE SITUATIONS INCLUDE: AS REQUIRED BY LAW, PUBLIC HEALTH ISSUES AS REQUIRED BY LAW, COMMUNICABLE DISEASES, HEALTH OVERSIGHT, ABUSE OR NEGLECT, FOOD AND DRUG ADMINISTRATION REQUIREMENTS, LEGAL PROCEEDINGS, LAW ENFORCEMENT, CORONERS, FUNERAL DIRECTORS, ORGAN DONATION RESEARCH, CRIMINAL ACTIVITY, MILITARY ACTIVITY AND NATIONAL SECURITY, WORKERS' COMPENSATION, INMATES, REQUIRED USES AND DISCLOSURES. UNDER THE LAW, WE MUST MAKE DISCLOSURES TO YOU AND WHEN REQUIRED BY THE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO INVESTIGATE OR DETERMINE OUR COMPLIANCE WITH THE REQUIREMENTS OF SECTION 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION, OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

YOU MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING EXCEPT TO THE EXTENT THAT YOUR THERAPIST OR THE THERAPIST'S PRACTICE HAS TAKEN AN ACTION IN RELIANCE ON THE USE OR DISCLOSURE INDICATED IN THE AUTHORIZATION.

YOUR RIGHTS

FOLLOWING IS A STATEMENT OF YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION.

YOU HAVE THE RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION, UNDER FEDERAL LAW, HOWEVER, YOU MAY NOT INSPECT OR COPY THE FOLLOWING RECORDS, PSYCOTHERAPY NOTES, INFORMATION COMPILED IN REASONABLE ANTICIPATION OF, OR USE IN, A CIVIL, CRIMINAL OR ADMINISTRATIVE ACTION OR PROCEEDING AND PROTECTED HEALTH INFORMATION THAT IS SUBJECT TO LAW THAT PROHIBITS ACCESS TO PROTECTED HEALTH INFORMATION.

YOU HAVE THE RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION. THIS MEANS YOU MAY ASK US NOT TO USE OR DISCLOSE ANY PART OF YOR PROTECTED HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS. YOU MAY ALSO REQUEST THAT ANY PART OF YOUR PROTECTED HEALTH INFORMATION NOT BE DISCLOSED TO FAMILY MEMBERS OR FRIENDS WHO MAY BE INVOLVED IN YOUR CARE OR FOR NOTIFICATION PURPOSES AS DESCRIBED IN THIS NOTICE OF PRIVACY PRACTICES. YOUR REQUEST MUST STATE THE SPECIFIC RESTRICTION REQUESTED AND TO WHOM YOU WANT THE RESTRICTION TO APPLY.

YOUR THERAPIST IS NOT REQUIRED TO AGREE TO A RESTRICTION THAT YOU MAY REQUEST. IF THE THERAPIST BELIEVES IT IS IN YOUR BEST INTEREST TO PERMIT USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION, YOUR PROTECTED HEALTH INFORMATION WILL NOT BE RESTRICTED. YOU THEN HAVE THE RIGHT TO USE ANOTHER HEALTH CARE PROFESSIONAL.

YOU HAVE THE RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS FROM US BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION. YOU HAVE THE RIGHT TO OBTAIN A PAPER COPY OF THIS NOTICE FROM US. UPON REQUEST, EVEN IF YOU HAVE AGREED TO ACCEPT THIS NOTICE ALTERNATIVELY I.E. ELECTRONICALLY.

YOU MAY HAVE THE RIGHT TO HAVE YOUR THERAPIST AMEND YOUR PROTECTED HEALTH INFORMATION. IF WE DENY YOUR REQUEST FOR AMENDMENT, YOU HAVE THE RIGHT TO FILE A STATEMENT OF DISAGREEMENT WITH US AND WE MAY PREPARE A REBUTTAL TO YOUR STATEMENT AND WILL PROVIDE YOU WITH A COPY OF ANY SUCH REBUTTAL.

YOU HAVE THE RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVE MADE, IF ANY, OF YOUR PROTECTED HEALTH INFORMATION. WE RESERVE THE RIGHT TO CHANGE THE ITEMS OF THIS NOTICE AND WILL INFORM YOU BY MAIL OF ANY CHANGES. YOU THEN HAVE THE RIGHT TO OBJECT OR WITHDRAW AS PROVIDED IN THIS NOTICE.

COMPLAINTS

YOU MAY COMPLAIN TO US OR TO THE SECRETARY OF HEALTH AND HUMAN SERVICES IF YOU BELIEVE YOUR PRIVACY RIGHTS HAVE BEEN VIOLATED BY US. YOU MAY FILE A COMPLAINT WITH US BY NOTIFYING OUR PRIVACY CONTACT OF YOUR COMPLAINT. **WE WILL NOT RETALIATE AGAINST YOU FOR FILING A COMLPAINT.**

THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON/OR BEFORE **APRIL 14, 2003.**

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF, AND PROVIDE INDIVIDUALS WITH, THIS NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION. IF YOU HAVE ANY OBJECTIONS TO THIS FORM, PLEASE ASK TO SPEAK WITH OUR HIPAA COMPLIANCE OFFICER IN PERSON OR BY PHONE.

SIGNATURE BELOW IS ONLY ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THIS NOTICE OF OUR PRIVACY PRACTICES:

_____	_____	_____
PRINTED NAME	SIGNATURE	DATE