PATIENT AND SUBSCRIBER INFORMATION

Patient Name: _____ **S.S. #**_____
(Last, First, M.I.)

Date of Birth _____/_____/_____ **Email**: _____

Address_____ Employer_____

_____ Employer's Address _____
City State zip
Phone #: Home_____ _____
City State zip
Work_____ Cell_____ Occupation_____

Patient's Sex M / F
Marital Status_____

Emergency Contact _____
Phone # Emergency Contact _____
Relationship (circle) spouse/ child/ friend/ parent/other

Is This A Worker's Comp Claim? _____
Is Injury Due to Auto Accident?_____
Is Legal Action Pending? _____
If Yes, Name & Phone of Attorney/Adjuster
_____
_____

Insured's Name _____ **Insured's Birthdate**_____
Insured's Address _____ **Patient's Relationship to the Insured (circle)**
Self / Spouse / Child / Other
_____
Insurance Company _____
Insured's I.D. # _____ **Do you have other ins.___ If yes,**
Group # _____ **Name of Company** _____
2nd Insurance I.D. #_____

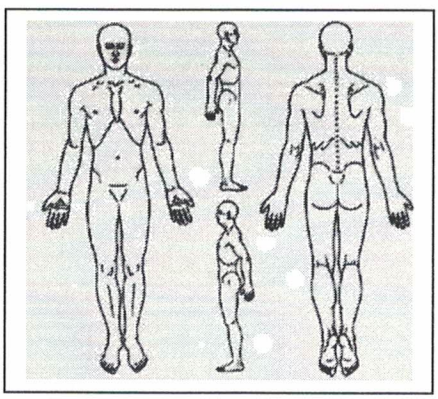
Date of Injury/Accident (if applicable) _____/_____
Brief Description of Accident _____
_____
How did you hear about us? _____
Date you first consulted your doctor for this injury _____
Name of the doctor referring you to Physical Therapy _____

Please List Recent and Related Injuries and Surgeries w/ Dates _____
_____

MEDICAL HISTORY (Please Circle)

Rate Your Average Pain over the Past Week
1 2 3 4 5 6 7 8 9 10
No Pain Moderate Pain Worst Possible Pain

PLEASE MARK YOUR AREA OF PAIN



Drug Allergy	Diabetes	Cancer
Blood Pressure	Seizures	Cardiac Arrhythmia
Osteoporosis	Stroke	Shortness of Breath
Heart Attack	Pacemaker	Coronary Artery Disease

Other _____

Please list all medications taken for your current problem and other medical conditions.

_____
_____
_____

MEDICAL SERVICES CONTRACT

I hereby authorize Chesterfield Physical Therapy, Inc. to release my information regarding medical history, diagnosis, and treatment of myself, or my dependent if applicable, to my referring physician and to my insurance company regarding my claim for benefits. In addition, I authorize release of any or all medical records to Chesterfield Physical Therapy, Inc.

I authorize payment directly to Chesterfield Physical Therapy, Inc., for the benefits otherwise payable to me under the terms of my insurance. I understand that I am financially responsible for all charges arising from the treatment of the patient listed below. I understand that any outstanding balance more than thirty (30) days past due will be subject to a finance charge of 1% per month which is an annual percentage rate of 12%.

If this contract is referred to an attorney or collection agency for collection, I agree to pay all attorney or collection fees in the amount of thirty-three percent (33%) of the total indebtedness and court costs incurred by Chesterfield Physical Therapy, Inc.

** I understand that a twenty-five dollar ($25.00) fee may be charged for appointments that I do not keep if I do not call to cancel with at least 24 hours' notice. I also understand that there may be a twenty-five ($25.00) charge for persistent cancellations**

INSURANCE COVERAGE INFORMATION

Insurance coverage varies with each type of insurance policy, and we suggest that you contact your insurance carrier if you have any questions. You may need to pay a deductible and/or a co-payment for services provided. We accept assignment from Anthem BCBS and Medicare among others. We will file your primary and secondary insurance if applicable. If your insurance company fails to pay for services within 90 days you will be responsible for payment of the account.

This AGREEMENT has been executed in, and shall be granted by, the laws of the State of Virginia. Any provisions hereof which for whatever reason may be held to be unenforceable shall not affect the validity of any other provision of this agreement.

Patient Name: _____ Date: _____

Signed (responsible party): _____

Notice of Privacy Practices Acknowledgment

I have received the notice of Privacy Practices and I have been provided an opportunity to review it.

Signature _____ Date _____

Agreement to Receive Electronic Mail from Chesterfield Physical Therapy

I would like to receive news, events & special offers exclusively for Chesterfield Physical Therapy and Massage.

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

Chesterfield Physical Therapy
1300 Alverser Plaza, Midlothian VA 23113
Pamela Wash, Privacy Officer at 804-378-9968 or fax 804-378-8870

Effective Date: January 1, 2017

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

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A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart [and on a computer]. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information.

4. Appointment Reminders or Missed Appointments. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Sale of Health Information. We will not sell your health information.

8. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

9. Public Health and Safety. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence.

10. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

11. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena.

12. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

13. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

14. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you and your preferred form and format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee, $10.00 + $.50 per page, and postage. This covers our costs for labor, supplies, postage. If a prepared explanation or summary is requested there will be a charge determined as to the extent of the summary needed. We may deny your request under limited circumstances. If we deny your request, you will have a right to appeal our decision.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to a list of those with whom we've shared your information. You can ask for a list (accounting) of the times we've shared your health information for 10 years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except those about treatment, payment and health care operations.

6. Right to a Paper or Electronic Copy of this Notice.

7. Right to file a complaint if you think your rights are violated. If you feel your rights have been violated by us in the handling of you health information you can file a complaint with our Privacy Officer listed at the top of this Notice of Privacy Practices. If you are not satisfied in how this office handles your complaint you may submit a formal complaint to:
U. S. Department of Health and Human Services Office for Civil Rights by sending letter to 200 Independence Avenue, S.W., Washington, D.C.20201 or calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hippa/complaints/. You will not be penalized in any way for filing a complaint
If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website, www.chesterfieldpt.com.