



Advanced Physical Therapy of Watertown, PLLC 26495 NYS Route 3 Watertown, NY 13601
Phone: (315) 782-0002 Fax: (315) 883-1333 www.APTOW.com

Registration Worksheet

Referring Doctor _____ Date Referred _____

Website Radio Word of Mouth Doctor Other

How did you come to hear of us? (you may circle multiple choices)

Name _____ Date of Birth _____ Email Address _____

Address _____ City _____ State _____ Zip Code _____

Chief Complaint/Diagnosis _____ Home Phone _____ Cell Phone _____

Male Female Single Married Divorced Student

Sex

Marital Status

Social Security Number _____

Place of Employment _____ Occupation _____ Work Phone _____

Guarantor Name _____ Place of Employment _____ Guarantor's Date of Birth _____

Address _____ City _____ State _____ Zip Code _____

Phone Number _____ Guarantor's Social Security Number _____

Notify in Case of Emergency _____ Phone Number _____ Relationship _____

Payment Method: Medicare Workman's Compensation Blue Cross
(Circle as appropriate)

Self-Pay Commercial Insurance

Tricare: (Complete below)

Sponsor _____

Social Security Number _____

Rank _____

Advanced Physical Therapy of Watertown, PLLC

Please describe your current complaint or limitation:

Please describe how your problem began:

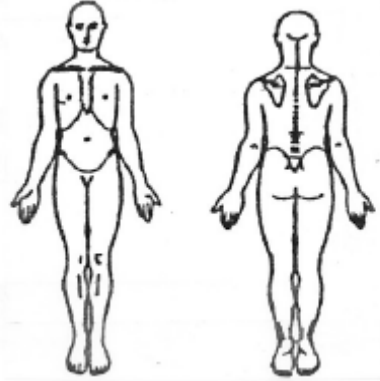
Please tell us when your condition started: _____

Specific date if possible: ___/___/___

Did you have surgery? No Yes Date ___/___/___

Please describe the nature of your pain:

- | | |
|-------------------------------------|---|
| <input type="checkbox"/> Sharp pain | <input type="checkbox"/> Constant (76 -100%) |
| <input type="checkbox"/> Dull Ache | <input type="checkbox"/> Frequent (51-75%) |
| <input type="checkbox"/> Throbbing | <input type="checkbox"/> Occasional (26 -50%) |
| <input type="checkbox"/> Numbness | <input type="checkbox"/> Intermittent (25% or less) |
| <input type="checkbox"/> Shooting | |
| <input type="checkbox"/> Burning | |
| <input type="checkbox"/> Tingling | |



Indicate the intensity of your *pain at rest*: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

Indicate the intensity of your *pain with movement*: (no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

Since this condition began, your symptoms have: decreased not changed increased

Your symptoms are worse in: morning afternoon night increased during the day same all day

In the past have you been treated for the same problem? Yes No

If yes, who did you see for the condition? MD Physical Therapist Chiropractor Other

What treatment did you receive? _____ When? ___/___/___

Occupation _____

Has your work status changed because of this condition? Yes No

Are you currently receiving home health services? Yes No

If you have ever had a listed condition in the past, please check it in the PAST column. If you are presently troubled by a particular condition, check it in the PRESENT column.

PAST	PRESENT	
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure (401.9)
<input type="checkbox"/>	<input type="checkbox"/>	Angina (413.9)
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack (410.9)
<input type="checkbox"/>	<input type="checkbox"/>	Stroke (436)
<input type="checkbox"/>	<input type="checkbox"/>	Asthma (493.9)
<input type="checkbox"/>	<input type="checkbox"/>	HIV / AIDS (042)
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (199.1) Location _____ Date ___/___/___
<input type="checkbox"/>	<input type="checkbox"/>	Tumor (229.9)
<input type="checkbox"/>	<input type="checkbox"/>	Systemic Lupus (710.0)
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (573.3)
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy (349.5)
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (250.0)
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis (714.0)
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (716.9)
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	Tobacco (305.1) Packs/day _____
<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Dependence (303.9)

Hospitalization/Surgical Procedures:

Medication: _____

Present Weight _____ Height _____

Patient's Signature _____ Date ___/___/___



General Consent for Treatment, Authorization and Assignment of Benefits, Release of Records or Information

General Consent for Treatment

I, the patient, _____, enter the Advanced Physical Therapy of Watertown, PLLC, clinic voluntarily for the purpose of diagnosis and medical treatment.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of diagnosis, treatment, test or examinations performed at Advanced Physical Therapy of Watertown, PLLC. I give my permission for the clinic to use my name in the general course of treatment on patient boards.

Authorization for Release of Information

The clinic may disclose all or any part of my/the patient's record to any person or corporation which is or may be liable under contract to the clinic for all or part of the clinic's charges, including but not limited to hospital or medical service companies, billing, insurance companies, workers' compensation carriers, welfare funds or my/the patient's employer. The clinic may disclose my Social Security number to any State or Federal government agencies, as required by law.

Assignment of Benefits/Payment Guarantee

I assign and instruct my insurance company(ies) to pay Advanced Physical Therapy of Watertown, PLLC, Directly for services. I request that payment of authorized benefits be made on my behalf. I understand that I am financially responsible for charges not covered by this assignment, including collection costs.

Medicare Certification

I certify that the information given by me in applying for payment under the Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release the Social Security Administration or its intermediaries or carriers, any information needed for this claim. I request that payment or authorized benefits be made on my behalf.

Release from Liability

I agree that the clinic shall not be liable for loss or damage to any personal property.

Patient/Relative/Guardian

Relationship to Patient

Date

Witness

Date



Cancellation Policy

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well being and gain of your physical abilities is something everyone in our clinic takes quite seriously.

In an attempt to provide the quality care for you, the following rules exist regarding patient appointments.

1. We expect you to keep **all** of your appointments. Write down the time of your visits so that you do not forget. ***If unable to keep an appointment, please call our office during business hours (8am - 4pm) twenty-four (24) hours in advance.*** The clinic does have an answering machine for you to leave a message if you must call after hours.
2. If you expect to be arriving more than ten (10) minutes late, please call ahead to confirm the appointment with the staff.
3. Any patient arriving more than fifteen (15) minutes late without contacting the office may not be able to be accommodated that date. A pattern of three (3) or more such instances may result in discharge.
4. **Any patient who has missed three (3) appointments and the therapist believes this may compromise treatment effectiveness, the patient may be discharged. At which time your physician will be notified that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.**
5. We do not “double book” appointments for our patients. Your appointment time is specifically for you. If you are not able to come to your appointment, please call us in advance. If you do not call 24 hours in advance during business hours or you do not show for your scheduled appointment, YOU, not your insurance, will be charged \$50 EACH time this occurs.

We realize that your time is valuable and every attempt is made by the staff to keep on time. However, please understand that unforeseen circumstances do occasionally arise during treatment time. Please accept our apology in advance for any additional wait beyond your scheduled appointment time and understand that you too will receive the same careful consideration during your treatment session.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

Patient Signature

Date

Witness

Date



We Respect Your Privacy

In order to respect your privacy in all areas, please answer the following questions to aid us in this process.

1. May we leave a message on your answering machine at home, or with someone in your household, if your appointment needs to be changed or cancelled?

If yes, whom can we leave the message with? _____

2. We are only permitted to release your medical information to your referring physician and your insurance company without further authorization from you. We cannot allow your information to be relayed to any family members, significant others, or anyone else without your consent. If there is a person you would like to be able to know your information directly from us, please list them below:

3. We strive at all times to keep treatment curtains closed during your treatment to protect the privacy of yourself and other patients. However, there may be times when you might need to use equipment in the gym area, or have treatment next to other patients where privacy in this way would be difficult. Please indicate below your preferences in this area:

_____ I prefer to always be in an area where there is a treatment curtain.

_____ I do not mind if I receive treatment in a more public fashion as long as the situation is described to me beforehand.

4. Do you have any other concerns regarding privacy? _____

5. Would you like to receive our patient newsletter? ___ yes ___ no

Patient signature

Date

Witness

Date



Advanced Physical Therapy of Watertown, PLLC
26495 NYS Route 3 Watertown NY 13601 Phone (315) 782-0002 Fax (315) 883-1333

Effective date of this notice: **06/01/2005**

If you have questions about this notice, please contact the person listed under "Whom to Contact" at the end of this notice.

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
AN HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.**

This notice applies to the following facility: Advanced Physical Therapy of Watertown, PLLC.

SUMMARY

In the course of receiving services from Advanced Physical Therapy of Watertown, PLLC, you will provide us with personal information about your health, with the understanding that this information will be kept confidential. We may also obtain information about your health from examinations, tests, or from others who have provided you with care. This Joint Notice of Privacy Practices is intended to inform you of the ways we may use your information and the occasions on which we may disclose this information to others.

We use patients' information when providing treatment, we disclose patients' information to other health care providers to assist them to provide you with treatment, we may disclose information to insurance companies as necessary to receive payment, we may use the information within our organization to evaluate quality and improve health care operations, and we may make other uses and disclosures of patients' information as required by law or as permitted by Advanced Physical Therapy of Watertown policies.

Information about HIV, alcohol and substance abuse treatment, mental health, and genetics is very sensitive and has additional protections under federal and state law. You may request a copy of our policy regarding disclosure of such information.

KINDS OF INFORMATION THAT THIS NOTICE APPLIES TO

This Notice applies to any information in our possession that would allow someone to identify you and learn something about your health. It does not apply to information that contains nothing that could reasonably be used to identify you.

WHO MUST ABIDE BY THIS NOTICE

Advance Physical Therapy of Watertown, PLLC

All health care professionals, employees, staff, students, volunteers and other personnel whose work is under the direct control of Advanced Physical Therapy of Watertown, PLLC.

OUR LEGAL DUTIES

We are required by law to maintain the privacy of your health information. We are required to provide you with this Joint Notice of Privacy Practices of our legal duties and privacy practices regarding health information. We are required to abide by the terms of the Notice until we officially adopt a new Notice, in which case we will be required to abide by the terms of the new Notice.

HOW WE MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

You will be asked to sign a consent allowing us to use and disclose your health information to provide you with treatment, obtain payment for our services, and run our health care operations. Here are examples of how we may use and disclose your health information with your consent.

Treatment. We will use your health information to provide you with medical care and services. This means that our employees, staff, students, volunteers, and others whose work is under our direct control, may read your health information to learn about your medical condition and use it to make decisions about your care. For instance, a physical therapist or physical therapist assistant may read your medical chart in order to care for you properly. We will also disclose your information to others who need it in order to provide you with medical treatment or services. For instance, we may send your doctor a summary of your progress made in therapy.

Payment. We will use your health information, and disclose it to others, as necessary to obtain payment for the services we provide to you. For instance, an employee in our business office may use your health information to prepare a bill. And we may send that bill, and any health information it contains, to your insurance company. We may also disclose some of your health information to companies with whom we contract for payment-related services. For instance, we may give information about you to a collection company that we contract with to collect bills for us. We will not use or disclose more information for payment purposes than is necessary.

Health Care Operations. We may use your health information for activities that are necessary to operate this clinic. This includes reading your health information to review the performance of our staff. We may also use your information and the information of other patients to plan what services we need to provide, expand, or reduce. We may also use your information and the information of other patients to plan what services we need to provide, expand, or reduce. We may also provide health information to students who are authorized to receive training here. We may disclose your health information as necessary to others who we contract with to provide administrative services.

They are called business associates and include our lawyers, auditors, accreditation services, and consultants, for instance. Any arrangements with business associates that allow disclosure of your health information will be subject to a written agreement that protects your privacy rights.

Below are examples of other uses and disclosures of health information we may make without your authorization.

Legal Requirement to Disclose Information. We will disclose your information when we are required by law to do so. This includes reporting information to government agencies that have the legal responsibility to monitor the health care system. For instance, we may be required to disclose your health information, and the information of others, if we are audited by Medicare. We will also disclose your health information when we are required to do so by a court order or other judicial or administrative process.

To Report Abuse. We may disclose your health information when the information related to a victim of abuse, neglect or domestic violence. We will make this report only in accordance with laws that require or allow such reporting, or with your permission.

Law Enforcement. We may disclose your health information for law enforcement purposes. This includes providing information to help locate a suspect, fugitive, material witness or missing person, or in connection with suspected criminal activity. We must also disclose your health information to a federal agency investigating our compliance with federal privacy regulations.

Specialized Purposes. We may disclose the health information of members of the armed forces as authorized by military command authorities. We may disclose your health information for a number of other specialized purposes. We will only disclose as much information as is necessary for the purpose. For instance, we may disclose your

information to coroners, medical examiners, and funeral directors; to organ procurement organizations (for organ, eye or tissue donation); or for national security, intelligence, and protection of the president. We also may disclose health information about an inmate to a correctional institution or to law enforcement officials, to provide the inmate with health care, to protect the health and safety of the inmate and others, and for the safety, administration, and maintenance of the correctional institution. We may also disclose your health information to your employer for purposes of workers' compensation and work site safety laws (OSHA, for instance).

To Avert a Serious Threat. We may disclose your health information if we decide that the disclosure is necessary to prevent serious harm to the public or to an individual. The disclosure will only be made to someone who is able to prevent or reduce the threat.

Family and Friends. We may disclose your health information to a member of your family or to someone else who is involved in your medical care or payment for care. We may notify family or friends if you are in the hospital, and tell them your general condition. In the event of a disaster, we may provide information about you to a disaster relief organization so they can notify your family of your condition and location. We will not disclose your information to family or friends if you object. However, in an emergency, we may disclose information that we determine is in your best interest.

Information to Patients. We may use your health information to provide you with additional information. This may include sending appointment reminders to your address. This may also include giving you information about treatment options or other health-care related services that we provide.

YOUR RIGHTS

Authorization. We may use or disclose your health information for any purpose that is listed in the Notice without your written authorization. We will not use or disclose your health information for any other reason without your authorization. If you authorize us to use or disclose your health information, you have the right to revoke the authorization at any time. For information about how to authorize us to use or disclose your health information, or about how to revoke an authorization, contact the person listed under "Whom to Contact" at the end of this notice. You may not revoke an authorization for use to use and disclose your information to the extent that we have taken action in reliance on the authorization. If the authorization is to permit disclosure of your information to an insurance company, as a condition of obtaining coverage, other laws may allow the insurer to continue to use your information to contest claims or your coverage, even after you have revoked the authorization.

Request Restrictions. You have the right to ask us to restrict how we use or disclose your health information. We will consider your request. But we are not required to agree. If we do agree, we will comply with the request unless the information is needed to provide you with emergency treatment. Also, we cannot agree to restrict disclosures that are required by law.

Confidential Communication. You have the right to ask us to communicate with you at a special address or by special means. For example, you may ask us to send mail to a different address rather than to your home. Or you may ask us to speak to you personally on the telephone rather than sending your health information by mail. We will not ask you to explain why you are making the request. We will agree to any reasonable request.

Inspect And Receive a Copy of Health Information. You have a right to inspect the health information about you that we have in our records, and to receive a copy of it. This right is limited to information about you that is kept in records that are used to make decisions about you. For instance, this includes medical billing records. If you want to review or receive a copy of these records, you must make the request in writing. We may charge a fee for the cost of copying and mailing the records. To ask to inspect your records, or to receive a copy, contact the person listed under "Whom to Contact" at the end of this notice. We will respond to your request to inspect your records within 10 days, and to your request to receive a copy of your records within 30 days.

Amend Health Information. You have the right to ask us to amend health information about you, which you believe is not correct, or not complete. We will respond to your request in writing within 30 days. We may deny your request if we did not create the information, if it is not part of the records we use to make decisions about you, if the information is something you would not be permitted to inspect or copy, or if it is complete and accurate.

Accounting of Disclosures. You have a right to receive an accounting of certain disclosures of your information to others. This accounting will list the times we have given your health information to others. The list will include dates of

the disclosures, the names of the people or organizations to whom the information was disclosed, a description of the information, and the reason. We will provide the first list of disclosures you request at no charge. We may charge you for any additional lists you request during the following 12 months. You must tell us the time period you want the list to cover. You may not request a time period longer than six years. Disclosures for the following reasons will not be included on the list: disclosures for treatment, payment or health care operations; disclosures for national security purposes; disclosures to correctional or law enforcement personnel; disclosures that you have authorized; disclosures made directly to you; disclosures made to your family and friends included in your care; disclosures incidental to permissible uses and disclosures of limited portions of your health information that do not directly identify you.

Paper Copy of this Privacy Notice. You have a right to receive a paper copy of this Notice. If you have received this notice electronically, you may receive a paper copy by contacting the person listed under "Whom to Contact" at the end of this Notice.

Complaints. You have a right to complain about our privacy practices, if you think your privacy had been violated. You may file your complaint directly with the Secretary of the US Department of Health and Human Services. All complaints must be in writing. We will not take any retaliation against you if you file a complaint.

OUR RIGHT TO CHANGE THIS NOTICE

We reserve the right to change our privacy practices, as described in this Notice, at any time. We reserve the right to apply these changes to any health information, which we already have, as well as to health information we receive in the future. Before we make any change in the privacy practices described in the Notice, we will write a new notice that includes the change. We will give you a copy of our revised Notice if you ask. The new Notice will include an effective date.

WHOM TO CONTACT

Contact the person listed below:

For more information about this Notice, or

For more information about our privacy policies, or

If you want to exercise any of your rights, as listed on this Notice, or

If you want to request a copy of our current Joint Notice of Privacy Practices.

Chantal S. Wilton

Advanced Physical Therapy of Watertown, PLLC

26495 NYS Route 3

Watertown NY 13601

(315) 782-0002

Joint Account Privacy Practices Acknowledgement of Receipt

This is to acknowledge that I have received a copy of the Advanced Physical Therapy of Watertown Joint Notice of Privacy Practices

Name: _____

Signature: _____

Signature of Legal Representative _____

Date: _____

Effective Date: January 1, 2006