

Physical Therapy & Rehab Concepts

Registration Form for Workman's Compensation Patients

(Please Print)

TODAY'S DATE ____ / ____ / ____

Patient Information					
FIRST NAME	MIDDLE INITIAL	LAST NAME	PATIENT'S BIRTHDATE / /	PATIENT'S SS#	GENDER M F
MAILING ADDRESS			CITY, STATE, ZIP CODE		
PERMANENT ADDRESS			CITY, STATE, ZIP CODE		
PRIMARY PHONE () -	SECONDARY PHONE () -		EMAIL ADDRESS (Never given out)		
IN CASE OF EMERGENCY CONTACT - NAME, RELATIONSHIP, PHONE #					
HOW DID YOU HEAR ABOUT US? <input type="checkbox"/> Doctor <input type="checkbox"/> Friend <input type="checkbox"/> Internet <input type="checkbox"/> Phn book <input type="checkbox"/> Other _____					
Case Information					
REFERRING PHYSICIAN		PRIMARY CARE PHYSICIAN		STATUS	
PROBLEM / COMPLAINT		RIGHT	LEFT	<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> FULL TIME STUDENT <input type="checkbox"/> PART TIME STUDENT <input type="checkbox"/> EMPLOYED	
HOW DID THE CONDITION OCCUR?			DATE OF INJURY / /		
Workman's Compensation Information					
INSURANCE CARRIER			CLAIM NUMBER		
ADJUSTER'S NAME & PHONE NUMBER () -					
EMPLOYER & EMPLOYER PHONE NUMBER () -			EMPLOYER ADDRESS		

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I also authorize Physical Therapy & Rehab Concepts and my insurance company to release any information required to process my claims.

I authorize the staff of PTRC to provide me with treatment as deemed necessary by my Dr. or Therapist.

X _____
PATIENT/GUARDIAN SIGNATURE
DATE

NOTICE OF PROVIDER PRIVACY PRACTICES

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.

Physical Therapy and Rehab Concepts (PTRC) must maintain the privacy of your personal health information and give you notice that describes our legal duties and privacy practices concerning your personal health information. In general, when we release your health information, we must release only the information we need to achieve the purpose of the use or disclosure. However, all of your personal health information that you designate will be available for release if you sign an authorization form, if you request the information yourself, to a provider regarding your treatment, or due to a legal requirement.

Again, without your written authorization, we can use your health information for the following purposes:

- *Treatment
- *Payment
- *Healthcare operations
- *As required by law
- *To those involved with your care or payment of your care

You have several rights in regard to your health information. You may contact Kim Farmer, Privacy Officer.

You can:

- *Inspect and copy your health information
- *Request to correct your health information
- *Request restrictions on certain uses and disclosures
- *Obtain a copy of this notice
- *Contact Privacy Officer

Effective since 4/14/03

By signing this form, you acknowledge that you have read and understand PTRC's privacy practices. A copy is available upon completion of form if requested.

I have read PTRC's Privacy Notice and know that I can discuss my concerns if need be regarding the privacy of my health information.

Patient's Signature

Date

