# PATIENT REGISTRATION FORM

Patient'sName_____
(First) (Middle Initial) (Last)

Street Address_____ Mailing_____

City_____State_____Zip_____Phone_____Cell phone_____

E-mail_____

Date of Birth____/____/____ Age_____ Date of Injury_____

Primary Care Physician/Internist_____ Referring Physician_____

Employer (If patient is a minor, please list parent's work info.) _____

Phone_____Address_____

Is this Worker's Comp? _____ If yes, name of contact person at work _____Phone_____

Spouse/Person to Contact in Case of Emergency_____

(H) phone _____ (C) phone_____

Spouse's Employer_____ (W) phone_____

Nearest relative not living with you_____

Address_____Phone_____

How did you hear of Blue Ridge Physical Therapy? _____

Have you retained the services of an attorney with regards to your injury? _____

I desire that physical therapy services be provided to me and understand it will be my responsibility to pay for these services if my insurance does not pay or if my insurance benefits are paid to me inadvertently. I request that payment of authorized insurance benefits for services be preassigned to Blue Ridge Physical Therapy. I understand that any balance remaining on my account after 30 days from the date of service is subject to interest charges at the rate of 1% per month. I understand I am responsible for certified mail fees, court costs, and attorney fees incurred as a result of collection efforts on this account. I give permission to contact me on any wireless telephone number provided and I understand that methods of contact may include pre-recorded voice messages and/or an automatic dialing device.

Medicare patients: I request that payment for services of authorized insurance benefits from my secondary insurance, _____, be preassigned to Blue Ridge Physical Therapy.

Signature of Medicare Patient: _____

Patient signature: _____Date_____

Patient Representative/Legal Guardian, if applicable_____

**PROVIDER NOTICE OF 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.

**Uses and Disclosures**: We use health information about you for treatment, billing, and healthcare operations. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose identifiable health information about you without your authorization in several situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. This form also serves as certification that you give your permission for the release of any and all medical records that would be beneficial to the processing of this claim or to further your rehabilitation.

**Your rights**: In most cases, you have the right to look at or get a copy of health information about you. If you request copies, we may charge you a fee. You also have the right to receive a list of certain types of disclosures of your information that we made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

**Our legal duty:** We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. If we make a significant change in our policies, we will change our notice and post the new notice in the waiting area.

You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

**Complaints**: If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact:

Privacy Officer: Bill Melchione

Address: 25 Crossing Ln. Suite 1
Lexington, VA 24450

Phone: (540) 463-5888 **Fax: (540) 463-4406**

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Acknowledgement of receipt of Notice of Privacy Practices:
Please sign your name and print your name and date on this acknowledgement form.

Patient Signature:_____Date:_____

Printed Name:_____Date of Birth_____

Patient Representative/Legal Guardian, if applicable:_____