Physical Therapy Associates, P.A.

Name:_____ **Employer:**_____
Nombre: **Trabajo:**

Address:_____ **Occupation:**_____
Direccion: **Su Ocupacion:**
City/State/Zip:_____ **Address:**_____

Phone (Home):_____ **City/State/Zip:**_____

Phone (Cell):_____ **Phone (Cell):**_____

Social Sec#:_____ **Referring Dr.:**_____
Seguro Social# **Doctor que le refiro**
Date of Birth:_____ **Marital Status:** ◯ **Married** ◯ **Single** ◯ **Other**

Insurance Information

Patient's relationship to insured: ◯ **Self** ◯ **Spouse** ◯ **Child** ◯ **Other:**_____

Primary INS CO:_____ **Secondary INS CO:**_____
Seguro Medico Primario **Seguro Medico Secundario:**

Insured's Name:_____ **Insured's Name:**_____
Nombre Del Asegurado **Nombre Del Asegurado**

Insured's Date of Birth:_____ **Insured's Date of Birth:**_____
Fecha de nacimiento del asegurado **Fecha de nacimiento del asegurado**

Please check below if appropriate and give the date of injury

Por favor marque lo que es apropiado y la fecha de accidente

Was this injury work related ?_____**Date:**_____ **Auto Accident:**_____**Date:**_____
Fue esto un accidente de trabajo? **Accidente de auto?**

If accident is work related or an auto accident, please give worker' comp or car carrier information.
Si fue accidente de trabjio o auto, por favor denos el seguro de compensacion o de carro.

_____

If an Attorney is involved, please give name, address and phone number.
Si hay un abogado representandole, de su nombre, direccion, y numero telefonico

_____

The patient responsible for all physical therapy fees, regardless of insurance coverage. I authorize the release of any and all medical information.
I authorize payments directly to the provider.
El paciente es responsible por los gatos de terapia sin depender de la cobertura del seguro. Yo autorizo la entrega de toda informacion medica necesaria. Yo tanbien autorizo que se pague directo al proveedor

_____ _____ _____
Name **Self / Parent / Guardian Signature of patient** **Date**

_____
Signature

PHYSICAL
THERAPY
ASSOCIATES, P.A.

Patient's Name:_____

Please be advised that if your insurance is an HMO, PPO, POS, Medicare or any other managed care, you will have a co-payment /co-insurance for each physical therapy visit. However should your insurance not pay for any dates of service this balance shall become patient responsibility. Thank You

_____ _____

Signature Date

Nombre Del Paciente:_____

Le hacemos saber que sis u seguro es un HMO, PPO, POS, Medicare, o cualquier otro tipo de cuidado medico administrado, usted tendra un co-pago/co-serguro por cada visita de terapia fiscia. Gracias

_____ _____

Firma Fecha

PHYSICAL
THERAPY
ASSOCIATES, P.A.

Patient Information Acknowledgment

I have read and fully understand Physical Therapy Associates, P.A. Notice to information Practices. I understand that Physical Therapy Associates, P.A. May use or disclose my personal health information for purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operation related to treatment of payment. I understand I have the right to restrict how my personal health information is used and disclosed for treatment, payment are administrative operations if I notify the practice. I also understand that Physical Therapy Associates, P.A. will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge the use and disclosure of my personal health information for purposes as noted in Physical Therapy Associates, P.A. Notice of information practices. I understand that I retain the right to revoke this consent by notifying the practice at any time.

_____
Patient Name

_____
Signature

_____
Date

PT ASSOCIATES, P.A.

NOTICE OF PATIENT INFORMATION PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY

PT ASSOCIATES, P.A. is required by law to protect the privacy of your personal health information. We are also required to provide this notice about our information practices and to follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

PT ASSOCIATES, P.A uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, contacting patients for appointment reminders, and other healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, or credentialing activities.

PT ASSOCIATES, P.A may disclose your health information to your referring physician or current health care provider, a family member or friend where appropriate, and other business associates we have contracted with to perform services. To protect your health information, however, we require business associates to appropriately safeguard your information.

PT ASSOCIATES, P.A may also use or disclose your personal health information without prior authorization for public health purposes, auditing purposes, research studies, and for emergencies. We also provide information when required by law. In any other situation, policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. PT ASSOCIATES, P.A will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that PT ASSOCIATES, P.A may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You will not be penalized for filing a complaint. You may also send a written complaint to the US Department of Health and Human Services. For further information on PT ASSOCIATES, P.A health information practices or if you have a complaint, please contact the following person:

PT ASSOCIATES, P.A
Privacy Officer
6280 Sunset Dr. #405
Miami, FL 33143
Tele: (305)662-4915 Fax: (305)662-8746

I have read and fully understand
PT ASSOCIATES, P.A Notice of Patient Information Practices. I understand that PT ASSOCIATES, P.A may use of disclose my personal health information for the purposes of carrying out treatment, obtaining payment, conducting internal administrative activities, contacting patients for appointment reminders, and other healthcare operations as described in the notice. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that PT ASSOCIATES, P.A will consider requests for restriction on a case by case basis, but is not legally required to accept them.
I hereby consent to the use and disclosure of my personal health information for purposes as noted in PT ASSOCIATES, P.A Notice of Patient Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Name:_____Signature:_____ Date:_____