Frontier Physical Therapy
115 Smelter Avenue NE, Suit e104
Great Falls, MT 59404
Phone (406) 727-2826
Fax (406) 727-3522
Email frontdesk@frontierpt.com

Name:_____ Date: _____
Last First MI

Address: _____
Street City State Zip code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security Number: _____ Date of Birth: _____ Sex: F [ ] M [ ]

Please check one: Child [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ]

Employer_____ Occupation: _____

Referring Physician: _____ Date of next visit: _____

Responsible Party: _____ Relationship to Patient: _____

Responsible Party Date of Birth: _____ Responsible Party SS Number: _____

Who should we contact in an emergency? _____ Phone: _____

How were you referred? (i.e. doctor, friend, yellow pages, internet, etc) _____

Email Address: _____

INSURANCE INFORMATION - Please allow the receptionist to make a copy of your insurance card(s).

Primary Insurance: _____ Insured's SS#: _____
Insured's Name: _____ Insured's DOB: _____
Insured's Employer: _____
ID Number: _____ Group Number: _____

Secondary Insurance: _____ Insured's SS#: _____
Insured's Name: _____ Insured's DOB: _____
Insured's Employer: _____
ID Number: _____ Group Number: _____

If you had an accident, please complete this section

Date of accident: _____ How did it happen? Auto [ ] Work [ ] Other [ ]
Insurance Company: _____ Adjuster: _____
Claim Number: _____ Attorney's Name: _____

Please Initial

CONSENT TO TREATMENT: I consent to rehabilitation and related services at FRONTIER PHYSICAL THERAPY. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature, including but not limited to areas of my body I may consider sensitive and/or private. _____

LIABILITY: I know and agree that FRONTIER PHYSICAL THERAPY is not responsible for loss or damage to personal valuables. _____

WAIVER AND RELEASE: I hereby release, discharge and acquit FRONTIER PHYSICAL THERAPY, it's agents, representatives, affiliates, employees, or assign, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and/or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. _____

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to FRONTIER PHYSICAL THERAPY and also authorize release of any medical records necessary to process medical claims. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. _____

INSURANCE CO-PAYMENTS: I understand that insurance co-payments, if applicable, are expected to be paid at the time of service, unless previous arrangements have been made with FRONTIER PHYSICAL THERAPY. _____

NOTICE OF PRIVACY: I acknowledge receipt of Notice of Privacy Practices. _____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature: _____ Date: _____

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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.

1) Uses and Disclosures We will use your protected health information (PHI) for the purposes of treatment, payment and health care operations.

Treatment includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians and other physical therapists. For example, we may feel that a stroke patient we are treating would benefit from an evaluation by a speech-language pathologist to address a swallowing difficulty. The health information we share with the speech-language pathologist would be considered a treatment related disclosure.

Payment includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was necessary.

Health Care Operations includes the utilization of your records to monitor the quality of care being given at our facility or for business planning activities.

Other Special Uses
Our practice may use your PHI to send you an appointment reminder, to inform you of our other health-related products and services, or to request a contribution to our charitable activities.

Uses and Disclosures Required by Law
The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions. We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about

you for workers' compensation or other similar programs that provide benefits for work-related injury or illness.

Your authorization is required before your PHI may be used or disclosed by us for other purposes.

2) Your Privacy Rights

Restrictions
You have the right to request restrictions on how your PHI is used, however, we are not required to agree with your request. If we do agree, we must abide by your request.

Confidential Communications
You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

Access to PHI
You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

Amendments
You have the right to request an amendment be made to your PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create.

Accounting of Disclosures
After April 14, 2003, you have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment, or health care operations or for which we have obtained authorization.

Complaints
If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy
We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

Effective Date: This Notice will take effect on April 14, 2003