Achieve Orthopedic Rehab Institute

www.achieveortho.com

Patient Information

Patient Name:	Date of Birth:
Patient Address:	City/State/Zip:
Patient Phone:	Patient Cell Phone:
Patient SSN:	Email Address:

Spouse Information

Spouse Name:	Spouse Date of Birth:
Spouse Employer:	Spouse Phone:

Patient's Employer Information

Employer Name:	Employer Phone:
City/State/Zip:	Occupation:

Emergency Information

Contact Name:	
Contact Phone:	Contact Relation:
Primary Care Physician:	**Referring Physician:**
Primary Care Phone:	**How did you hear about us?:**

Insurance: □

Primary Plan: □ HMO □ PPO □ EPO □ POS □ Medicare

Insurance Policy ID:	Insurance Group:
Insurance Name:	Insurance Telephone:
Policy holder's Name:	Date of Birth:

Secondary Plan: □

Insurance Policy ID:	Insurance Group:
Insurance Name:	Insurance Telephone:
Policy holder's Name:	Date of Birth:

Injury Case: □

Injury Date:					
Employee Related:	□ Yes	□ No	Auto Related:	□ Yes	□ No
Post-Operative:	□ Yes	□ No	W/C Claim:	□ Yes	□ No
Other Accident:	□ Yes	□ No	W/C Claim Number:		

Worker's Compensation: □

W/C Carrier:	W/C Phone:
W/C Address:	W/C City & State:

Attorney: □

Attorney Name:	Attorney Phone:
Attorney Address:	Attorney City & State:

We strive to provide you with the most accurate benefit information this however is not a guarantee of coverage. Should you feel that the information provided to you may be in error we encourage you to contact your insurance carrier. Co-Payment amounts are specified by the terms of the member's benefit agreement and are the Patient's responsibility at the time of service. These fees are not negotiable.

I herby authorize the above information as accurate. Any remaining unpaid balance will be my responsibility.

Signed: ______________________________ Date: ____________________

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APTA
American Physical Therapy Association
The Science of Healing. The Art of Caring.
CREDENTIALED RESIDENCY PROGRAM

Patient Health Information Consent Form

We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. A HIPAA NOTICE is available to you at the front desk should you require more detailed information.

- The patient understands and agrees to allow this Achieve Orthopedic Rehab Institute to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow Achieve Orthopedic Rehab Institute to submit requested information to the Health Insurance Company provided to us by the patient for the purpose of payment.

- The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections, please keep in mind that when requesting records a fee may apply. The patient may request to know what disclosures have been made. Should any restrictions be submitted in writing, our office is not obligated to agree to those restrictions.

- A patient's written consent need only be obtained one time for all subsequent care given the patient in this office. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

- We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them. Patients have the right to file a formal complaint about any possible violations of these policies and procedures.

- If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the Achieve Orthopedic Rehab Institute Physical Therapist has the right to refuse care.

Consent for Release and Use of Confidential Information

I hereby give my consent to Achieve Orthopedic Rehab Institute to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record.

I understand that the physical therapist has reserved a right to change his or her privacy practices that are described in the notice. I also understand that a copy of any revised notice will be provided to me or made available at the office visit.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physical therapist. I also understand that I will not be able to revoke this consent in cases where the physical therapist has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physical therapist’s office.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

/ /

Name of Patient/Guarantor Date

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CONSENT/AUTHORIZATION FORM

Achieve Physical Therapists:

- ☐ Ashraf Abdelhamid, PT, MS, OCS
- ☐ Larry Olver, PT, MS, OCS, FAAOMPT
- ☐ Anita Galco, DPT, ATC
- ☐ Young Jee Filer, PT, MPT, OCS
- ☐ Unsoo Kim, PT, DPT
- ☐ Paula Johnson, PT, MOMT
- ☐ Robert Johnson, PT, MS, OCS
- ☐ Philip A. Kushner, PT, DPT, OCS
- ☐ Katarzyna Sacha, PT, OMPT, FAAOMPT
- ☐ Phillip Sparacino, PT, DPT, OCS
- ☐ David McCartney, PT, MS, ATC
- ☐ Amanda Schaffer, PT, MS, OCS

CONSENT FOR TREATMENT: I authorize any of the above-named physical therapist(s), to perform treatments including but not limited to: Therapeutic Exercises, Pain Treatment Modalities (interferential ultrasound, e-stimulation, ice, and/or heat) and Manual Therapy.

I also certify that no guarantee or assurance has been made as to the results that may be obtained. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me. I understand that I may stop treatment at any time.

RELEASE OF MEDICAL RECORD: In order to ensure proper follow-up and continuity of care, I agree that a copy of my medical record may be released to my physician, a designated referral physician, and/or the referral provider. I hereby authorize **Achieve Orthopedic Rehab Institute** to release to my insurance company any information acquired in the course of my examination or treatment which is necessary to process claims for services rendered.

INSURANCE AUTHORIZATION: I request that payment of authorized benefits be made to the above-named therapist(s) on my behalf for any services provided to me. I authorize a release of any medical and/or patient information needed to determine benefits or benefits for related services to any insurance company, any other third party payer, state medical assistance agency and/or any other governmental private payer responsible for paying such benefits. I agree to pay for all my charges not covered. I authorize a copy of this authorization to be used in place of the original.

LATE/CANCELLATION/NO SHOW POLICY: In an effort to be as available to our patients as possible we ask that you give 24 hour notice of cancelling an appointment. Should you be running late please contact the office to confirm that they will still be able to accommodate your visit. We recognize that punctuality is not always possible but we appreciate your understanding. Please note that if you fail to keep two consecutive appointments and have not called to reschedule, your subsequent appointments will be cancelled.

Signed: ____ Date: _____________