Suburban Physical Therapy
Accessibility. Experience. Results.
2132 Case Parkway North, Ste. A • Twinsburg, OH 44087 • P/ 330.963.2920 • F/ 330.963.2921
6950 South Edgerton Road • Brecksville, OH 44141 • P/ 440.746.1730 • F/ 440.746.1732
www.suburbanpt.com

REGISTRATION INFORMATION - *Please print all information*

LAST NAME	FIRST NAME	M.I.	NICKNAME
STREET ADDRESS	**CITY**	**STATE**	**ZIP CODE**

E-MAIL ADDRESS:	BIRTHDATE	AGE	MARITAL STATUS	OCCUPATION

HOME PHONE #	CELL PHONE #	BUSINESS PHONE #
( )	( )	( )
CONTACT ☐ YES ☐ NO	CONTACT ☐ YES ☐ NO	CONTACT ☐ YES ☐ NO

How did you hear about our office: ☐ Physician ☐ Family/Friend ☐ Insurance ☐ Phone Book ☐ Internet

☐ Other_____

Primary Care Physician:	Have you previously received physical therapy?
	☐ YES ☐ NO
Referring Physician:	If Yes, when_____ where _____

RESPONSIBLE PARTY INFORMATION: (Person assuming financial responsibility for account.)

LAST NAME	FIRST NAME	M.I.	RELATIONSHIP TO PATIENT
STREET ADDRESS	**CITY**	**STATE**	**ZIP CODE**

BIRTHDATE	CELL/HOME PHONE #	BUSINESS PHONE #
	( )	( )
	CONTACT ☐ YES ☐ NO	CONTACT ☐ YES ☐ NO

EMPLOYER	EMPLOYER ADDRESS

BILLING INFORMATION:

I authorize the above provider to release my medical/financial information to my referring physician/primary care physician, insurance, third party payer or this provider's collection agents, attorneys and consultants necessary to pay for services rendered. I also know that I am responsible for deductibles, co-insurance and any services not covered by my insurance. If the patient is a minor, I as a parent/guardian authorize treatment. If uninsured, I will be responsible for all charges at the time of the visit. I further authorize all payments to be made directly to this provider.

Date	Signature of Patient/Responsible Party

I understand that I am primarily responsible for payment of all charges/services rendered regardless of the status of my claim before the Bureau of Workers Compensation. I authorize release of any medical/financial records to insurance, caseworkers, third party payers or this provider's collection agents, attorneys and consultants necessary to obtain payment for services rendered. I further authorize all payments directly to this provider.

Date	Signature of Patient/Responsible Party

Athlete: I authorize the above provider to release medical information to my coach/trainer regarding my condition, in order to facilitate continued care.

Date	Signature of Patient/Responsible Party

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MEDICAL HISTORY FORM

Name _____ **Date** _____

Height_____ **Weight**_____

List any allergies you have to drugs, food or other items:

_____

_____

List major operations:

Operation Performed	Year
_____	_____
_____	_____
_____	_____

(Female Patients): Are you currently pregnant: (Please Circle) Yes No

Have you had any of the following illnesses: (Please Check)

☐ Diabetes	☐ Heart Disease	☐ Rheumatoid Arthritis
☐ High Blood Pressure	☐ Heart Attack	☐ Osteoarthritis
☐ Low Blood Pressure	☐ Chest Pain/Angina	☐ Asthma
☐ Congestive Heart Failure	☐ Cancer	☐ Seizures
☐ COPD/ Lung Disease	☐ Stroke	☐ Hepatitis
☐ Osteoporosis/Osteopenia		

Are you currently receiving any homecare services? (nursing, blood pressure checks, physical therapy, etc.) (Please Circle) Yes No

Other serious illnesses: (Please Explain):

_____

_____

Emergency Contact Name and Phone Number:

_____

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVATE PRACTICES

Patient Name:_____ Account #_____

Address:_____

I have been given the opportunity to read a copy of the *Suburban Physical Therapy Notice of Privacy Practice,* which describes how my health information is used and shared. I understand that *Suburban Physical Therapy* has the right to change this "Notice" at any time. I may obtain a copy by contacting the Facility Privacy Designee or by visiting *Suburban Physical Therapy*.

My signature below acknowledges that I have been given the opportunity to read the Notice of Privacy Practice.

_____ _____
Signature of patient/responsible party Date

_____
Print Name

For office use only: Complete this section if you are unable to obtain a signature.

1. If the patient or responsible party is unable or unwilling to sign this Acknowledgment, or the acknowledgment is not signed for any other reason, state the reason:

_____
_____
_____
_____

2. Describe the steps taken to obtain the patients or responsible party signature on the acknowledgment.

_____
_____
_____
_____

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Effective 01/01/15

Please Read Carefully

In order to ensure that our patients receive timely physical therapy services, Suburban Physical Therapy has instituted an appointment cancellation/"no show" policy for all physical therapy appointments. Please read the policy below and sign in the space provided.

"NO SHOW"/CANCELLATION POLICY

In today's hectic world, unplanned issues come up for all of us. At Suburban Physical Therapy, we will gladly reschedule your appointment up until 24 hours before your appointment. In other words, you must cancel your scheduled appointment by calling us a minimum of 24 hours in advance. That way, the open slot can be filled with someone needing an appointment.

Cancellation Fees: Failure to provide the required 24 hours notice will result in missed appointment fees. These fees are not covered by insurance carriers or Medicare and will be your responsibility to pay before or at the time of your next visit.

$25 fee for cancelling less than 24 hours in advance;

$50 fee if you do not call to cancel your appointment and do not show up;

We reserve the right to waive these fees in cases of unavoidable emergencies.

Waiting List: Three consecutive cancellations or "no-shows" will result in being put on the waiting list for your next appointment. You will not be allowed to schedule an appointment ahead of time. You will have to call in on the day you want to be seen and **if an appointment is available**, you will be scheduled for that day.

Possible Discharge from Physical Therapy: Three consecutive "no-shows" will result in automatic discharge from physical therapy due to non-compliance with your treatment plan.

The Suburban Physical Therapy cancellation/"no show" policy is designed to open otherwise unused appointments for our patients, not to collect missed appointment fees. Your cooperation and consideration are appreciated.

I _____, agree to comply with this policy.
(please print name)

_____ _____
Signature (patient or guardian) Date

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Patient Privacy Protection Policy Notice

As required by the HIPAA Regulations, Suburban Physical Therapy, Inc., protects all medical records and other individually identifiable health information used or disclosed by the clinic, whether electronically, on paper, or orally. Patients of (Clinic Name), have significant new rights to understand and control how their health information is used.

Our Patients may view, request a copy of, amend, or receive a list of individuals and organizations that have seen their medical information during the period of the previous six (6) years. Suburban Physical Therapy, Inc., may deny access to a patient's records if it believes that the release of certain information will endanger the life or physical safety of the individual. In all other cases, Suburban Physical Therapy, Inc., has sixty (60) days from the date of request to make the information available. Suburban Physical Therapy, Inc., may provide a summary of the data instead of the actual data itself and may charge a fee that is usual and customary for providing this information. Such amounts are set by law and revised on an annual basis. Suburban Physical Therapy, Inc., is not required to include the following material: (i) information that is known to be inaccurate or (ii) information that is not part of the patient's record set.

Patient education on privacy protections. Suburban Physical Therapy, Inc., is required to develop a Notice of Privacy Practices (the "Notice"). The Notice must explain, in plain English, how the clinic may use and disclose a patient's personally identifiable health information. The clinic is required to maintain the Notice in a visible location and must provide each patient with a physical copy of the Notice.

Ensuring patient access to their medical records. Patients will be able to view and obtain copies of their records. They may also request amendments to their records to reflect inaccuracies in the medical record. In addition, a history of non-routine disclosures must be made accessible to patients. Applicable copy charges will be in accordance with state law.

Receiving patient consent before information is released. Suburban Physical Therapy, Inc., is not required to obtain patient consent before sharing their information for treatment, payment, and health care operations. However, a separate patient authorization must be obtained for non-routine disclosures and most non-health care purposes. Patients will have the right to request restrictions on the uses and disclosures of their information.

Providing recourse if privacy protections are violated. Patients will have the right to file a formal complaint with Suburban Physical Therapy, Inc., or with the Department of Health and Human Services ("HHS"), concerning violations of the provisions of the Regulations or any related policies and procedures of the clinic.