AMPT
Advancing Movement with Physical Therapy

PATIENT REGISTRATION FORM

Registration Information:

Date of Birth: _____ Gender: Male ☐ Female ☐ SSN: _____

Patient's Name: _____
First Middle Initial Last

Home Address: _____ Phone: Home (____)_____
Street Address Apt. # Cell (____)_____

_____ Email: _____
City State Zip

How would you like to receive appoinment reminders? Text Message ☐ Email ☐
For text messages, please identify your service provider: _____

Personal Information:

Occupation: _____ Employer(if applicable): _____
Employer Address: _____ Phone: Work (____)_____
Street Address Suite # *ext:* _____

_____
City State Zip

Marital Status: Single ☐ Married ☐ Domestic Partner ☐ Widowed ☐
Emergency Contact: _____ Phone: Home (____)_____
Relation: _____ Phone: Cell (____)_____
Phone: Work (____)_____

If Patient is a Minor or requires a Legal Guardian:

Date of Birth: _____ Gender: Male ☐ Female ☐

Legal Guardian: _____
First Middle Initial Last

Home Address: _____ Phone: Home (____)_____
Street Address Apt. # Cell (____)_____

_____ Email: _____
City State Zip

Insurance Information: ☐ Cards Provided

Primary Provider: _____ Group #: _____
Home Address: _____ ID #: _____
Street Address Suite # Policy #: _____

_____ Phone: (____)_____
City State Zip Fax: (____)_____

Secondary Provider: _____ Group #: _____
Home Address: _____ ID #: _____
Street Address Suite # Policy #: _____

_____ Phone: (____)_____
City State Zip Fax: (____)_____

Tertiary Provider: _____ Group #: _____

Home Address: _____ ID #: _____

Street Address Suite # Policy #: _____

_____ Phone: (____)_____

City State Zip Fax: (____)_____

Consultation Information:

Reason for Consultation: _____

_____

_____

Referring Physician: _____ Phone: (____)_____

Date of last visit: _____ Fax: (____)_____

Family Physician: _____ Phone: (____)_____

Date of last visit: _____ Fax: (____)_____

Are you here to be treated for a work-related injury? ☐ Yes ☐ No

Patients with Medicare Only:

Have you received Physical Therapy or Speech Therapy Services anywhere else this calendar year? ☐ Yes ☐ No

Are you currently receiving Home Health services (Physical Therapy, Occupational Therapy, Speech Therapy, Nursing, etc.)?

☐ Yes ☐ No

CONSENT TO PHYSICAL THERAPY EVALUATION AND TREATMENT (PLEASE READ)

1. I hereby consent to the evaluation and/or treatment by the licensed physical therapists employed by or under contract with AMPT Rehab for myself, my child, or the person for whom I serve as their legal guardian. I understand, acknowledge and affirm that such evaluation and/or treatment may involve bodily contact, touching, and/or direct contact of a sensitive nature.

I further acknowledge that I have received and understood an explanation concerning the nature and process of the procedures, evaluation and course of treatment; and an AMPT Rehab employee and/or contracted employee has witnessed my signature of this consent in his or her presence. I attest that a licensed physical therapist employed or contracted by AMPT Rehab has informed me of some expected health benefits and possible complications and/or discomfort, which may result from skilled physical therapy care. In addition, a licensed physical therapist employed or contracted by AMPT Rehab has explained to me the risks of receiving no treatment.

Furthermore, a licensed physical therapist employed or contracted by AMPT Rehab has also explained that there is not guarantee that the proposed course of treatment will improve the condition of myself, my child, or the person for who I serve as their legal guardian; and that it is possible, although unlikely, that the course of treatment may cause additional pain and/or discomfort or aggravate the condition of myself, my child, or the person for who I serve as their legal guardian. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I understand that it is my right to ask any further questions concerning the care and/or condition of myself, my child, or the person for who I serve as their legal guardian throughout the time spent under the care of AMPT Rehab. I confirm that I have read and fully understand this consent form.

2. I, as parent and/or legal guardian of a patient receiving treatment here at AMPT Rehab, do hereby agree and understand that I have been advised to remain on the premises during any such treatment; and waive any claim I may have resulting from failure to do so.

3. I acknowledge and affirm that AMPT Rehab is not responsible for loss or damage to personal valuables.

4. I hereby release, discharge and acquit AMPT Rehab, it's agents, representatives, affiliates, employees, or assigns, 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.

5. I hereby assign all benefits directly to AMPT Rehab and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. 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.

I understand that I have the right to refuse to sign this form and would therefore withhold consent for physical therapy services provided by AMPT Rehab and/or any of its employees or contracted employees.

Thank you for choosing us as a provider - Welcome to AMPT Rehab

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Physical Therapist Signature: _____ Date: _____

AMPT, LLC
www.amptrehab.com
Email: ampttx@gmail.com

2020 North Loop West, Suite 135
Houston, TX 77018
(P) 281-816-7891
(F) 281-674-8276

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date: October 1, 2015

This Notice of Privacy Practices applies to the following organizations.

All outpatient facilities under AMPT Rehab.

If you have questions, contact the Privacy Officer, Michael Furtado at ampttx@gmail.com or 281-816-7891.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received AMPT, LLC Notice of Privacy Practices for protected health information.

Name of Patient: _____ Date:_____
Printed Name

Signature of Patient: _____ Date:_____

If applicable:
Name of Legal Guardian: _____ Date:_____
Printed Name

Signature of Legal Guardian: _____ Date:_____

FOR STAFF USE ONLY:

Documentation of good Faith Effort to Obtain Written Acknowledgement
I made a good faith effort to obtain the patient's written acknowledgement of our Notice of Privacy Practices for protected health information by (check all that apply):

_____ Showing the patient the Notice of Privacy Practices Posted in our office.
_____ Giving the patient the Notice of Privacy Practices to read prior to receiving any treatment for service.
_____ Asking the patient to sign this Acknowledgement Form.
_____ Other (explain) _____

I was unable to obtain the patient's written Acknowledgement because (check all that apply):
_____ The patient refused to sign this form.
_____ The patient would not sign the form because the patient said he/she did not understand the notice.
_____ Other (explain) _____

Signature: _____ Date:_____
Staff Member

Note: This written acknowledgement must be completed no later than the first date of health care services or treatment are provided to the patient after October 1, 2015. This Acknowledgement must be retained in the patient's permanent records.

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____