HAMPSTEAD PHYSICAL THERAPY
25 N. HAMPSTEAD VILLAGE DR.
HAMPSTEAD, NC 28443
P. (910) 270-6026 F. (910) 270-6028

SNEADS FERRY PHYSICAL THERAPY
1072 NC HWY 210, STE. D
SNEADS FERRY, NC 28460
P.(910) 327-0418 F. (910) 327-2490

TOPSAIL PHYSICAL THERAPY
2660 NC HWY 210 E # 102
HAMPSTEAD, NC 28443
P.(910) 803-2424 F. (910) 803-2525

Patient Information and Assignment of Insurance Benefits

Patient Name: ______________________________________ Date: _________________________

Social Security #: _________________________________ Date of Birth: ___________________

MAIL Address: ____

City: ______________________State: _______Zip: ____________ Home Phone: ___________

Cell Phone: ____________________________ Email: ___________________________________

Would you like to receive appointment reminders via email? Yes or No

Would you like to receive appointment reminders via text? Yes of No

Person to contact in case of an emergency: ____

Phone: ___________________________________ Relation: _______________________________

Are you currently receiving any type of medical care in your home? YES or NO

Physician Information

Referring Physician: ________________________ Current Date of Injury: __________________

Office Address: ___________________________________ Phone:_________________________

Insurance Information

Primary Insurance:____

Secondary Insurance:____

Policy Holder's Name: _____________________SS# ________________Birth Date:________

~I give my consent to Hampstead Physical Therapy (HPT), Sneads Ferry Physical Therapy (SFPT)or Topsail PT (TPT) therapists to provide treatment, examination, and/or evaluations as deemed necessary to the above named patient.

~I understand that HPT and/or SFPT will submit insurance claims on my behalf as a courtesy and will assist me in filing claims in every responsible way. I understand that my insurance represents a contract between me (or my employer) and a health insurance company, and HPT, SFPT and/or TPT will act on my behalf. ~I hereby authorize payment directly to HPT, SFPT and/ or TPT of any insurance benefits otherwise payable to me for services. I understand that I am directly responsible to HPT, SFPT and TPT for any charges not covered by my insurance company. ~If my insurance company has not paid their portion within 60 days from the start of treatment, I understand that I am responsible for payment at that time. Any balance remaining due after the insurance payment has been received will be billed and due within 30 days.

Print Name: ____ **Date**: ______________

Signature: ____

Name:_________________________ DOB:____________________ Date:______________________

Medical History

Existing or Relevant Previous Conditions

Condition		Condition		Condition	
Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinsons	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High/Low blood pressure	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No		

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Weight ______________________ Height:____________________

Fall History

- ☐ Injury as a result of a fall in the past year?
- ☐ Two or more falls in the last year?
- ☐ Patient is at risk for falls?

Surgical History

Body Region: ____________________ Surgery Type: ______________________ Date: _____________, ______, _________

Body Region: ____________________ Surgery Type: ______________________ Date: _____________, ______, _________

Body Region: ____________________ Surgery Type: ______________________ Date: _____________, ______, _________

Body Region: ____________________ Surgery Type: ______________________ Date: _____________, ______, _________

Current Medications

Drug: _______________ Dosage: _______ Frequency: ___________ Route: ___________ Reason Taking: ______________________

Drug: _______________ Dosage: _______ Frequency: ___________ Route: ___________ Reason Taking: ______________________

Drug: _______________ Dosage: _______ Frequency: ___________ Route: ___________ Reason Taking: ______________________

Drug: _______________ Dosage: _______ Frequency: ___________ Route: ___________ Reason Taking: ______________________

☐ **Currently not taking any medications**

HAMPSTEAD PHYSICAL THERAPY
25 N. HAMPSTEAD VILLAGE DR.
HAMPSTEAD, NC 28443
P. (910) 270-6026 F. (910) 270-6028

SNEADS FERRY PHYSICAL THERAPY
1072 NC HWY 210, STE. D
SNEADS FERRY, NC 28460
P.(910) 327-0418 F. (910) 327-2490

TOPSAIL PHYSICAL THERAPY
2660 NC HWY 210 E # 102
HAMPSTEAD, NC 28443
P.(910) 803-2424 F. (910) 803-2525

Cancellation Policy

We require 24 hours notice in the event an appointment has to be cancelled. In light of several missed appointments we have been forced to charge a $30.00 fee for any appointment not canceled 24 hours in advance. A "NO SHOW" fee of $45.00 will be charged to patient who do not call or show up for their apt. Three " Patients arriving more than 15 minutes late for their appointment may need to be rescheduled.
PLEASE INITIAL ____________.

Receipt of Notices of Privacy Practices and Medicare Therapy Cap Written Acknowledgement

I have received a written copy of the Notice of Privacy Practices, Notice of the Medicare Therapy Cap, and Cancellation Policy from the medical office indicated above.
PLEASE INITIAL ____________.

Financial Policy

If you have health insurance our office will file your insurance for you and apply any payments and adjustments that may apply. However, you remain responsible to pay Co-payments, Deductibles, and Co-insurance amounts at the time service is rendered.
PLEASE INITIAL _____________.

If you do not have Health Insurance the initial evaluation is $90.00. Every visit there after is $75.00. At the conclusion of your visit the balance will be due and payable.
PLEASE INITIAL _____________.

I have read, understand and will comply with the Cancellation Policy, the HIPPA & Medicare Cap Policy, and the Financial Policy written above. My initials along with my signature confirm this.

Name Print: ____

Name Signature:____

Date: ____

HAMPSTEAD/SNEADS FERRY PHYSICAL THERAPY/TOPSAIL Physical Therapy 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.

This notice describes our Practice's policies, which extend to:
Any health care professional authorized toenter information into your chart (includingphysicians, PAs, RNs, etc.);
All areas of our Practice (front desk, administration, billing and collection, etc.);All employees, staff and other personnelthat work for or with our Practice;

OUR THOUGHTS ABOUT YOUR PROTECTED HEALTH INFORMATION:

We understand that your medical information ispersonal to you, and we are committed toprotecting medical information about you. As our patient, we create paper and electronicmedical records about your health, our care foryou, and the services and/or items we provide to you as our patient. We need this record toprovide for your care and to comply with certainlegal requirements. This notice applies to all of the records of your care generated by the Practice.We are required by law to: make sure that the protected health information about you is kept private; provide you with a Notice of our Privacy Practices and your legal rights with respectto protected health information about you;andfollow the conditions of the Notice that iscurrently in effect.

HOW WE MAY USE AND DISCLOSEMEDICAL INFORMATION ABOUT YOU.

The following categories describe different waysthat we use and disclose protected healthinformation that we have and share with others.
Each category of uses or disclosures provides ageneral explanation and provides some examples of uses. Not every use or disclosure in a categorywill be listed. However, all of the ways we arepermitted to use and disclose your medicalinformation will fall into one of these categories.

Medical Treatment.
We use medical information about you to provide you withmedical treatment or services. We maydisclose medical information about you todoctors, nurses, technicians, medicalstudents, or hospital personnel who areinvolved in taking care of you. Forexample, a doctor to whom we refer you forongoing or further care may need yourmedical record. Different areas of ourpractice also may share medical informationabout you including your record(s),prescriptions, lab work and x-rays. Wealso may obtain and use information fromyour other health care providers. For example, we may need to obtain information from your pharmacies about drugs you are currently taking or have taken in the past to ensure a medicine we prescribe is appropriate.

Payment.We may use and disclose medical information about you so that the services and procedures you receive may be billed and collected from you, an insurance company, or a third party. For example, we may give your health care information about treatment you receive to your health plan to obtain payment or reimbursement for the care. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may also disclose your medical information to another health care provider for that provider's payment activities concerning you.

Health Care Operations.
We may use and disclose medical information about you so that we can run our practice more efficiently and make sure that all of our patients receive quality care. These uses may include reviewing our treatment and services to evaluate the performance of our staff, deciding what additional services to offer and where, deciding what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes. We may also combine the medical information we have with medical information from other practices to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning the identities of specific patients.

Individuals Involved In Your Care or Payment for Your Care. We may disclose medical information about you to people outside the practice who may be involved in your medical care or who may be involved in paying for your care. This may include your family members, friends or personal representatives such as a guardian or other person who has been appointed to handle your medical decisions. You can object to these releases by telling us that you do not wish any or all individuals involved in your care to receive this information. If you are not present or cannot agree or object, we will use our professional judgment to decide whether it is in your best interest to release relevant information to someone involved in your care.

Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose medical information about you to tell you about or recommend treatment alternatives and health-related benefits or services that may be of interest to you, provided that, if we receive financial remuneration for such communications, we will inform you of your right to opt out of such communications.

Business Associates. There are some services provided by our Practice through contacts with business associates, such as attorneys who help us comply with legal requirements, auditors to verify our records, billing companies to aid us in the billing process and the like. We may disclose your medical information to these business associates, but we will require the business associate to appropriately safeguard your medical information.

Appointment and Patient Recall Reminders.
We may ask that you sign in writing at the Receptionists' Desk, a "Sign In" log on the day of your appointment. We may use and Disclose medical information to contact you as a reminder that you have an appointment for medical care with us. This contact maybe by phone, e-mail, mail or otherwise and may involve sending an e-mail, leaving a message on an answering machine, or otherwise contacting you in a manner which could be received or intercepted by others.

Emergency Situations.
We may disclose medical information about you to an organization assisting in a disaster relief effort or in an emergency situation so that your family can be notified about your condition, status and location.

Research.
Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who receive one medication to those who received another, for the same condition. All research projects are subject to a special approval process, which evaluates a proposed research

project and its use of medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process.

Required By Law.
We will disclose medical information about you when required to do so by federal, state or local law. To Avert a Serious Threat to Health orSafety.We may use and disclose medical information about you when necessary to prevent a serious threat either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Organ and Tissue Donation.
If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans.
If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation.
We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks.
We may disclose medical information about you for public health activities. These activities generally include the following: to prevent or control disease, injury or disability; to report deaths to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; to notify the appropriate government authority if we believe an adult patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities.
We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes.
If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. . We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested. We may also use such information to defend ourselves or any member of our Practice in any actual or threatened action.

Law Enforcement.
We may release medical information if asked to do so by a law enforcement official: In response to a court order, subpoena, warrant, summons or similar process; To identify or locate a suspect, fugitive, material witness, or missing person; About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; About a death we believe may be the result of criminal conduct; About criminal conduct at the Practice; and In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors.
We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about deceased patients to funeral directors as necessary to carry out their duties.

Inmates.
If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

National Security and Intelligence Activities.
We may release your medical information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. We may also disclose your medical information to authorized federal officials so that they may provide protection to the President and other authorized persons or foreign heads of state or conduct special investigations.

OTHER RESTRICTIONS ON USE OF MEDICAL INFORMATION

We may be restricted by other applicable law from making disclosures of medical information about you, in which case we will follow the provisions of the applicable law. For example, if you receive treatment for drug or alcohol abuse or mental health issues, we are generally not able to release this information to anyone unless you authorize us to do so or a court of law requires it. Also if you are tested or treated for HIV or AIDS, we are generally prevented from releasing this information unless you give us permission or we are required or permitted by law or by a court order or subpoena to do so. In addition if you are under the age of 16, are not married and have not been emancipated by a court of law, we generally are restricted from releasing information about treatment you receive for pregnancy, drug and alcohol abuse, venereal disease, or emotional disturbance unless the you consent or your doctor determines that the information needs to be shared with your parents because of a threat to your life or health or if your parent or guardian contacts your doctor and specifically asks about your treatment for these conditions. Finally, uses or disclosures of psychotherapy notes, uses or disclosures of medical information for marketing purposes, and uses or disclosures for which the Practice receives direct or indirect financial remuneration may generally only be made with your written permission or authorization.

OTHER USES OF MEDICAL INFORMATION.

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission or authorization. If you provide us with your written permission or authorization to use or disclose medical information about you, you may revoke that permission or authorization, in writing, at any time. If you revoke your permission or authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to

retain our records of the care that we provided to you.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION.

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy.
You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but, in certain circumstances, may not include psychotherapy notes or other mental health records. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to our Privacy Officer. Ask the front desk person for the name of the Privacy Officer. If you request a copy of the information, we may charge a fee for thecosts of copying, mailing or other supplies (tapes, disks, etc.) associated with your request. We may deny your request to inspect and copy in certain very limited circumstances.
If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome and recommendations from that review.

Right to Request An Amendment.
If you feel that the medical information we have about you in your record is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the Practice maintains your medical record. To request an amendment, your request must be submitted in writing to the Privacy Officer, along with your intended amendmentand a reason that supports your request to amend. The amendment must be dated and signed by you.
We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: Was not created by us, unless the person or entity that created the information is no longer available to make the amendment; Is not part of the medical information kept by or for the Practice; Is not part of the information which you would be permitted to inspect and copy; or Is inaccurate and incomplete.

Right to an Accounting of Disclosures.
You have the right to request an "accounting of disclosures." This is a list of the disclosures we made concerning your medical information, but does not include disclosures made for treatment, payment or health care operations, or for purposes or disclosures specifically authorized by you. To request this list, you must submit your request in writing to our Privacy Officer. Your request must state a time period not longer than six (6) years and may not include dates before April 14, 2003.. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions.
You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a particular treatment you received to a family member.
We are not required to agree to your request unless the requested restriction concerns information to a health plan for payment or health care operations and pertains solely to an item or service which you or someone on your behalf, other than the health plan, and has paid in full.If wedo agree, we will comply with your requestunless the information is needed to provide you emergency treatment.To request restrictions, you must make your request in writing to our Privacy Officer. In your request, you must indicate:
what information you want to limit;
whether you want to limit our use, disclosure or both; and
to whom you want the limits to apply, (e.g., disclosures to your children, parents, spouse, etc.)

Right to Request Confidential Communications.
You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, that we not leave voice mail or e-mail, or the like. To request confidential communications, you must make your request in writing to our Privacy Officer. We will not ask you the reason for your request. We will accommodate all *reasonable* requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice.
You have the right to a paper copy of this notice.You may also ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy, request one from one of our assistants or call the Privacy Officer.

CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we may receive from you in the future. We will post a copy of the current notice in the Practice and on our website, which can be found at www.hampsteadpt.com. In addition, each time you visit the Practice for treatment or health care services you may request a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer.
All complaints must be submitted in writing, and all complaints shall be investigated, without repercussion to you.
You will not be penalized for filing a complaint.
If you have any questions or complaints, please contact:
Privacy Officer
HAMPSTEAD/SNEADS FERRY PT
This Notice of Privacy Practices has an Effective Date of July 24, 2013

Notice of Medicare Therapy Cap

Coverage by Medicare will be limited for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services for services received on January 1, 2017 through December 31, 2017. The limits are $1960for PT, SLPT & OT. Medicare pays up to 80% after the deductible has been met. These limits do include outpatient PT and SLP at hospital outpatient clinics. If the maximum limit is reached an Advanced Beneficiary Notice will need to be signed assuming all financial responsibility for future treatment for the specific year. You may call 1-800-MEDICARE if you have further questions regarding PT, SLP & OT limits.