

Cool Springs Physical Therapy
1051 E. Cornell Rd.
Mercer, PA 16137

P.T. _____

Diag: 1. _____

2. _____

3. _____

4. _____

Please Print

Patient Name: _____ Social Security#: _____

Address: _____
City State Zip

Height: _____ Weight: _____ Birth date: _____ Age: _____ Sex: M F Marital Status: S M W D

Phone# _____ Cell Phone#: _____ email address: _____

Employer: _____ Occupation: _____

Work/School Address: _____ Phone #: _____

Referring Physician: _____ Primary Care Physician: _____

Please list two emergency contacts outside of your residence:

Name: _____ Phone: _____

Name: _____ Phone: _____

Is this a worker's compensation injury? Yes/No Is this an Auto Accident? Yes/No

Claim#: _____ Date of Injury: _____ Phone#: _____

Primary Insurance: _____ Subscriber: _____

Relationship to Patient: _____ Subscriber's date of birth: _____

Secondary Insurance: _____ Subscriber: _____

Relationship to Patient: _____ Subscriber's date of birth: _____

I understand that I am ultimately responsible for payment of all services rendered, unless otherwise provided by law. This may include, but not limited to, *deductibles* and all *copays*. Payment is expected when services are rendered unless prior arrangements have been made.

Signature

Date

Revised 6/09

COOL SPRINGS PHYSICAL THERAPY
NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

TMS PHYSICAL THERAPY'S LEGAL DUTY

Cool Springs Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Cool Springs Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, **Cool Springs Physical Therapy** may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Cool Springs Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, **Cool Springs Physical Therapy's** policy is to obtain your written authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Cool Springs Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purpose.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. **Cool Springs Physical Therapy** will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that **Cool Springs Physical Therapy** may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on **Cool Springs Physical Therapy's** health information practices or if you have a complaint, please contact the following person:

I have read and fully understand **Cool Springs Physical Therapy's** Notice of Information Practices. I understand that **Cool Springs Physical Therapy** may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that **Cool Springs Physical Therapy** will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in **COOL SPRINGS PHYSICAL THERAPY'S** Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Signature

Date

COOL SPRINGS PHYSICAL THERAPY

Phone:(724) 662-2800 1051 East Cornell Road, Mercer, PA 16137

Fax:(724) 662-4666



TIMOTHY M. SCHELL, P.T.

Cancellation / No Show Policy

Effective March 1, 2007

Cool Springs Physical Therapy is initiating
A Cancellation / No Show Policy

Here at Cool Springs Physical Therapy we realize that once in a while circumstances require you to cancel or miss an appointment and we are happy to reschedule your appointment when this happens.

While canceling appointments can create scheduling problems, it also interrupts your rehabilitation program for your injury / condition. Frequent cancellations and no shows make our treatment less effective toward reaching your goals and the goals of your referring physician. Please attend all treatments, if possible, so that together we can reach your full potential and maximum recovery.

As a courtesy to our staff and to all our patients and in order to better serve ALL of our patients, please call us at least 24 hours in advance with your cancellation. Without proper notification, a fee may be charged to you personally for the missed appointment. If you arrive at the wrong time for your appointment, we will make every effort to provide your entire treatment as long as we do not inconvenience those patients already scheduled for that day.

We are pleased that you chose Cool Springs Physical Therapy for your physical therapy rehabilitation. Please partner with us to help make your recovery here at Cool Springs Physical Therapy a successful experience.

I have read and I do understand that a fee may be charged to me if I do not cancel an appointment within 24 hours.

Signature

Date

HOW DID YOU HEAR ABOUT COOL SPRINGS PHYSICAL THERAPY?

Patient Name: _____ Date: _____

(Please check ONLY ONE that applies)

_____ I am a returning patient

_____ Doctor Referral

_____ Employer

_____ Mailing

_____ Health Club

_____ Insurance Company

_____ Newspaper

_____ Radio

_____ School

_____ Sign on building

_____ Computer

_____ Family or Friend referral

_____ Location

_____ Health Fair

_____ Other _____

THANK YOU!