for my visit at Northgate Physical Therapy, P.C.

Name		Date of Birth (DOB)	
Last	MI		
Parent/Guardian(if minor)Address		Sex Age SSN	
City		Home/Cell Phone	
Responsible Party	Phone	Work Phone	
Emergency Contact	Relationship	Contact phone	
I grant permission for parent/spouse to rec	eive information regarding r		
Referring Physician's office			
Have you ever been to Northgate Physical			
Type of Claim: Workers' Compensation Date of Injury (DOI):	n Private Incurance		
For Workers' Comp: Employer Co Name_		Claim#	
	on Insurance		
Private Insurance: Primary Insurance		Group/Policy#	
Primary Insured Name:		DOB	
Tricare: Sponsor ID	Sponsor Name & DOB		
I hereby grant permission to Northgate Phy necessary. I authorize information and sub commercial insurance company, employer, Northgate Physical Therapy, P.C. to release bills to any insurance company or other this treatment. I further authorize release of contreatment. I further authorize the use of sai assign, transfer, and set over to Northgate Freimbursement under my insurance policy.	vsical Therapy, P.C. to perform sequent visits to be relayed and/or workers' compensation and medical information nerd-party payer who is, or may pies to the referring physicial directords for the purpose of Physical Therapy, P.C. all of	rm such medical procedures they deverbally, written or faxed to my famous insurance carrier if applicable. It excessary for the processing and payre y be responsible, for paying for medical processing and payre or physicians consulted in regard workers' compensation disclosure.	
I understand that Northgate Physical Th Medicaid. I certify that I am NOT a Medicare or Medicaid recipient that I wi	dicare or Medicaid recinier	at I also understand that if I am	

By my signature below, I authorize Northgate Physical Therapy, P.C. to treat me, and understand the medical expenses shall be my responsibility. I understand that I am responsible to obtain information regarding my insurance benefits and payments coverage. Northgate Physical Therapy, P.C. is not responsible to obtain this information.

	Date	
(Dation t		_
(ratient sign	ure or Parent Signature if patient is a minor)	

FINANCIAL POLICY

Workers' Compensation Patients

The employee is responsible to report a workers' compensation injury in writing within four (4) days. The employer is responsible to fill out and mail a first report of injury to their insurance carrier within 10 days of injury notification.

The insurance company is responsible to pay within 30 days of receiving the workers' compensation bill. If the employer fails to file the first report of injury, the employee must file his/her own first report of injury or be responsible for the bill.

If the insurance carrier denies the claim for any reason, the patient will be responsible for the bill.

In-network and Auto Insurance

We will submit your insurance claims for you. If you have had an auto accident, we will also require the claim number and mailing address of the insurance company. Please note that you are responsible for your copay, if applicable, at time of service. If coverage is denied for any reason, you will be responsible for the entire amount of your bill. Your costs will be determined upon the completion of claims processing according to your individual insurance plan.

Out-of-network Insurance

If we are not a preferred provider for your insurance company, you may elect to pay cash.

Cash-pay rates are as follows and all payable at time of visit:

Physical Therapy Evaluation and Treatment = \$80/visit ROM Testing = \$100/visit FCE Testing = \$500/visit

Payment guarantee

I hereby authorize the above insurance companies to pay any benefits for my care to Northgate Physical Therapy, P.C. directly. I have read this policy and understand that, regardless of any insurance coverage, including government agencies and third-party providers that f may have, I am responsible for payment of my account. In consideration of services to be provided, I agree to pay Northgate Physical Therapy, P.C. in accordance with the regular rates and terms of Northgate Physical Therapy, P.C. Returned checks are subject to a \$50 service charge per check. Balances over 60 days will acquire an interest rate of 12% annum. I agree that in the event that my account is turned over to a collection agency or attorney due to non-payment, that I will pay up to an additional 50% of the balance as reasonable collection fees (to be added to the balance at the time the account is placed for collection) plus any court costs and attorney's fees incurred in connection with the collection of my account.

I understand my responsibility for payment of my account with Northgate Physical Therapy, P.C. and have provided, to the best of my ability, the information requested accurately and completely.

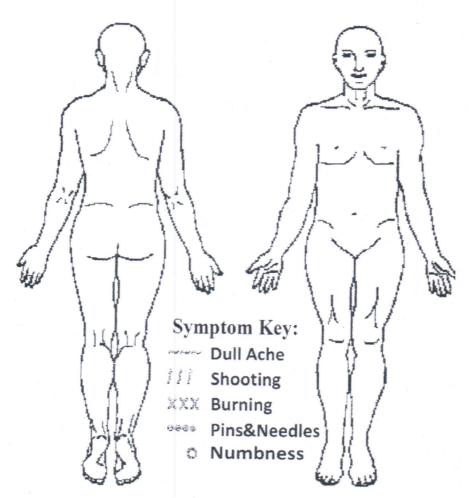
By signing below, I verify that I have read and agree to the above financial policy. I understand that I am responsible for payment of treatment of a minor if applicable.

(A parent/guardian must sign if the patient is a minor/17 or younger).

Signature:		Date:
	(Patient signature or parer	it signature if patient is a minor)

Pain Drawing

Please describe your current symptoms by marking on the drawing below, using symbols shown in the "Symptom Key", to indicate specific types of sensation:



The above chart is an accurate description of my current symptoms.

Claimant Signature	Date

Northgate Physical Therapy, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse To Sign This Acknowledgment" have received a copy of this office's Notice of Privacy Practices. Print Name Signature Date For Office Use Only We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, acknowledgment could not be obtained because: Individual refused to sign Communication barriers prohibited obtaining the acknowledgment An emergency situation prevented us from obtaining acknowledgment Other (please specify)



HIPAA Email Consent

- HIPAA stands for the Health Insurance Portability and Accountability Act
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy security protections for health information.
- Information stored on our computers is encrypted.

- Most popular email services do not utilize encrypted email.

- When we send you an email, the information that is sent is not encrypted. T means a third party may be able to access the information and read it since transmitted over the Internet. In addition, once the email is received by yo someone may be able to access your email account and read it.
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA Act, the federal government provide guidance on email and HIPAA.
- The information is available in a pdf (page 5634) on the U.S. Department of Hea and Human Services website:

http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf

-The guidelines state that if a patient has been made aware of the risks of unencry email, and that same patient provides consent to receive health information via e then a health entity may send that patient personal medical information via unen email.

ALLOW UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission to No Physical Therapy, P.C. to send me personal health information and general correspondence via unencrypted email.

Signature (parent or guardian if patient is a minor)	Date	Printed Name	
Please print email address			