Dubrow Physical Therapy and Golf Fitness
601 West Plano Parkway, Suite 141-A
Plano, TX 75075

Patient Registration Form

Today's Date: _____ Who referred you to Dr. Dubrow? _____

Date of Birth: _____

Name: _____
First Middle Last

Address: _____
Street No. Street Name Apartment No.

_____
City State Zip Code

Home Phone: _____ Cell Phone:_____

E-mail: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed Sex: ☐Male ☐Female

Employer: _____
Name Address

Occupation: _____ Work Phone: _____

Emergency Contact:
(not living in household) _____

Relationship:_____ Phone No.:_____

If patient is a child, parent's name(s):_____

Insurance Information:

Insurance Company:_____

Member ID No:_____ Group No.:_____

Name of Cardholder:_____ Cardholder's Date of Birth:_____

Cardholder's Employer:_____ Occupation of Cardholder:_____

Patient's Relationship to Cardholder:_____

If an injury, was it due to an auto accident? ☐Yes ☐No Employment? ☐Yes ☐No

State in which accident occurred:_____ Date of accident:_____

Other injury? ☐Yes ☐ No If yes, please explain:_____

Date of injury (if other than accident):_____

Referring Physician:_____ Phone No.:_____

Present Medications:_____

_____

Allergies:_____

NEXT PAGE PLEASE

Dubrow Physical Therapy and Golf Fitness
601 West Plano Parkway, Suite 141-A
Plano, TX 75075

Financial Policies

We are dedicated to providing the best possible physical therapy service to you. Your complete understanding of your financial responsibilities is an essential element of your care and treatment. If you have any questions about our financial policies, please do not hesitate to discuss them with us.

Fees:

We make every effort to follow the guidelines required by your insurance company; however, every contract is unique. Every effort is made to file claims electronically on your behalf with your insurance company. Unfortunately, if we are unable to collect payment from your insurance company within one hundred and twenty (120) days, you **may** be held financially responsible. Therefore, we encourage our patients to be pro-active in assuring that claims are paid.

Guaranty of Payment:

As a courtesy to our patients, we will file your primary insurance claims electronically pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") regulations. Since every insurance policy is unique, you are responsible for any unpaid portions, including but not limited to, co-payments and unmet patient portions (such as deductibles, co-insurance rates, etc.). These amounts are due at the time of service. Unmet portions will be handled in two ways:

- **The entire unmet portion is due at the time of service.** Every effort is made to estimate the amount of the unmet portion due; however, this is an estimate, and may be higher or lower after the treatments are complete and after your insurance company reports an Explanation of Benefits ("EOB") back to us. If you have overpaid and are due a refund, (a) refunds are processed for payment within thirty (30) days of notification from the insurance provider, you, or an EOB that a refund is due; and (b) we will provide the refund in the form of a paper check. We will either give the refund check to you at your next appointment or mail the refund check to your last known address, whichever is more expedient.

- **Credit card information will be maintained on file as a guaranty of payment.** Once a response is received from your insurance carrier, your balance due will be handled as follows: (a) if you are a current patient continuing to receive physical therapy services, at your next appointment you will be notified and asked to pay the balance due at that time; (b) if you have finished your course of physical therapy treatment, you agree that the balance due will be charged to your credit card on file, and a copy of the receipt will be e-mailed to you. Should your credit card payment be declined for any reason and you fail to make satisfactory arrangements for payment, a claim may be filed against you in small claims court or your account may be referred for outside collection.

NEXT PAGE PLEASE

Dubrow Physical Therapy and Golf Fitness
601 West Plano Parkway, Suite 141-A
Plano, TX 75075

Please provide your credit card information below. No one has access to our files. Our cabinets are locked, as is the private front office, and the clinic, every day. Your information is secure. **You will not be treated without providing your credit card information below.**

Number:_____ Expiration Date:_____
CCV Code:_____

Medicare and Medicaid Patients:

We do not file insurance with Medicare and/or Medicaid. We have had patients successfully file insurance claims with Medicare themselves; however, we cannot advise you regarding whether Medicare will reimburse you for any amounts paid for physical therapy services. If covered by Medicare and/or Medicaid, you will be considered a self-pay patient and will be fully responsible for the charges incurred for physical therapy services.

Self Pay Patients:

In an effort to provide quality care to all, we offer self-pay patients discounted rates. These fees are due at the time of service.

Method of Payment:

This office accepts cash, check, VISA and MasterCard. A fee of $35.00 will be assessed for each returned check, and charges for services and fee on any returned check must be paid by cash or credit card.

I have read and understand the financial policies of Dubrow Physical Therapy and I agree to be bound by their terms.

_____ _____
Printed Name of Patient *Date*

_____
Signature of Patient or Responsible Party

NEXT PAGE PLEASE

Dubrow Physical Therapy and Golf Fitness
601 West Plano Parkway, Suite 141-A
Plano, TX 75075

Assignment

HMO and PPO PATIENTS:

I, the undersigned certify that I (or my dependents) have coverage with _____, and assign directly to **Karen Dubrow Physical Therapy, P.C.** all insurance benefits, if any, otherwise payable to me for services rendered. **I understand I am financially responsible for all charges whether or not paid by insurance.** I authorize the use of this signature on all insurance submissions.

_____ _____

Printed Name of Patient *Date*

_____

Signature of Patient or Responsible Party

NEXT PAGE PLEASE

Dubrow Physical Therapy and Golf Fitness
601 West Plano Parkway, Suite 141-A
Plano, TX 75075

Notice

Dubrow Physical Therapy has been able to continue to offer incomparable orthopedic manual physical therapy for over thirty (30) years. Continuing the services provided, including the quality, skills, attention, and time, has not been easy with the progressive cut backs of managed care. Many other physical therapy clinics have 4 – 5 patients scheduled each hour per physical therapist.

As of January 1, 2017, *if this office does not receive advance notification at least 24* ***business hours*** *prior to your appointment a* ***$150.00 "non-cancellation" fee*** *will be charged to your credit card.* Because Dr. Dubrow does not double or triple book patients like many doctor and physical therapy offices do, when a patient does not give ample time for a cancellation Dr. Dubrow is essentially unemployed for that time. Dr. Dubrow continues to have to pay the bills and also refuses to diminish the quality of care; therefore, **the cancellation policy is strict and will not be waived**. This enables her to keep her doors open for you.

We are a boutique business and will continue to provide you with unsurpassed care.

Thank you for your cooperation. Dr. Dubrow and her staff look forward to providing you continued excellent and personal service.

I give my authorization to charge my credit card the $150.00 non-cancellation fee in case I do not follow the above cancellation policy. I have read and understand this policy.

_____	_____
Printed Name of Patient	*Date*
_____	_____
Signature of Patient or Responsible Party	*Dubrow Office Signature*

Thank you for your cooperation. Dr. Dubrow and her staff look forward to providing you continued excellent and personal service.

NEXT PAGE PLEASE

Dubrow Physical Therapy and Golf Fitness
601 West Plano Parkway, Suite 141-A
Plano, TX 75075

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed by this office and how you can get access to this information. Please review it carefully. After reviewing this notice, you will be asked to sign that you have received this notice.

Dubrow Physical Therapy is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. This Notice describes how we will use and disclose your health information in our office. The policies outlined in this Notice apply to all of your health information generated by us in our office, whether recorded in your medical record, invoices, payment forms, or other ways. If you have questions about any part of this Notice or if you want more information about the privacy practices at Dubrow Physical Therapy please contact:

Designated Privacy Official
601 West Plano Parkway, Suite 141-A
Plano, TX 75075
972.398.0789
Effective Date of This Notice: May 1, 2014

A. 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.

1. Get a Copy of Your Medical Record. You can ask to see or get a copy of your medical record and other health information this office has about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within thirty (30) days of your request. We may charge a reasonable, cost-based fee.

2. Ask us to Correct Your Medical Record. You can ask our office 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 sixty (60) days.

3. Request Confidential Communications. You can ask us to contact you in a specific way (for example, by home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

4. 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.

5. 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 (6) 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 twelve (12) months.

6. 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.

7. 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.

8. File a Complaint if You Feel Your Rights are Violated. You can complain if you feel we have violated your rights by contacting our Designated Privacy Official (see above). You can also file a complaint with the Office for Civil Rights or you may visit: www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

B. 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.

1. 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; and share information in a disaster relief situation. 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.
2. In These Cases we *NEVER* Share Your Information Unless you Give us Written Permission: Marketing purposes and the sale of your information.

PLEASE READ AND SIGN BACK SIDE OF NOTICE

Dubrow Physical Therapy and Golf Fitness
601 West Plano Parkway, Suite 141-A
Plano, TX 75075

C. Our Uses and Disclosures.

We typically use or share your health information in the following ways:

1. Treatment: 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.

2. Running Our Office: We can use and share your health information to run our office, improve your care, and contact you when necessary. *Example*, we use health information about you to manage your treatment and services.

3. Billing 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.

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.

4. 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; and preventing or reducing a serious threat to anyone's health or safety.

5. Do Research: We can use or share your information for health research.

6. 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.

7. Respond to Organ and Tissue Donation Requests: We can share health information about you with organ procurement organizations.

8. 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.

9. 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; and for special government functions such as military, national security, and presidential protective services.

10. 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. We make a concerted effort to contact you before we respond to a subpoena.

D. Our Responsibilities.

1. We are required by law to maintain the privacy and security of your protected health information.

2. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

3. We must follow the duties and privacy practices described in this Notice and give you a copy of it.

4. 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.

E. Changes to this Notice. We may 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.

F. This Notice applies to:

Dubrow Physical Therapy
601 West Plano Parkway, Suite 141-A
Plano, TX 75075
dubrowoffice@sbcglobal.net
972.398.0789

G. The Effective Date of Notice is May 1, 2014.

Patient Acknowledgement: By signing my name below, I acknowledge receipt of a copy of this Notice, and my agreement to its terms.

_____ _____

Printed Name of Patient *Date*

_____

Signature of Patient or Responsible Party

Dubrow Physical Therapy and Golf Fitness
601 West Plano Parkway, Suite 141-A
Plano, TX 75075

DISCLOSURE RECORD OF PATIENT INFORMATION

The Health Information Portability and Accountability Act ("HIPPA") privacy rule gives a patient the right to deny certain uses and disclosures of their personal health information ("PHI"). The patient is also provided the right to request confidential communication and the manner in which the information is received.

Please note that restrictions in our ability to contact you may result in missed calls and miscommunication. We encourage you to make any restrictions that are necessary, but remember that communication is essential to effective healthcare.

I can be contacted in the following manner:

☐ ***Home Telephone_____***
Please check one
- ☐ ***O.K. to leave message with detailed information***
- ☐ ***Leave message stating Dr. Dubrow's name and call back number only***

☐ ***Work Telephone_____***
Please check one
- ☐ ***O.K. to leave message with detailed information***
- ☐ ***Leave message stating Dr. Dubrow's name and call back number only***

☐ ***Cell Phone_____***
Please check one
- ☐ ***O.K. to leave message with detailed information***
- ☐ ***Leave message stating Dr. Dubrow's name and call back number only***

☐ ***Written Communication***
Please check all that apply
- ☐ ***O.K. to mail to my home address***
- ☐ ***O.K. to fax to this number:***
  _____

☐ ***Verbal Communication***
Please check and fill out all that apply
- ☐ ***O.K. to speak to spouse/significant other***
  Name:_____
- ☐ ***O.K. to speak to child(ren)***
  Name(s):_____
  _____
  _____
- ☐ ***O.K. to speak to parent(s)***
  Name(s):_____
  _____
  _____
- ☐ ***O.K. to speak to my (note relationship(s))_____***
  Name(s):_____
  _____

FOR OFFICE USE ONLY

Date	***Disclosed to Whom (Phone or Fax # or Address***	***Purpose of Disclosure***	***Disclosed By (Initials)***