NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Our practice is dedicated to maintaining the privacy of your protected health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PID. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. You may request copies of your electronic records to be sent to you electronically or by mail.

We will use and disclose your protected health information for treatment, payment and healthcare operation. We request that you read our notice of privacy practices.

I have received a copy and agree to Galloway Therapy, PLLC notice of privacy practices.

I, _____, give the therapists and staff of Galloway Therapy, PLLC permission to discuss my diagnosis, procedures and/or treatment with the person(s) listed below.

Name(s):	Relationship:
_____	_____
_____	_____
_____	_____

Signature: _____ Date: _____

PATIENT MISSED APPOINTMENT POLICY

Our commitment to your well-being and gain of your abilities is something everyone in our clinic takes quite seriously. Because we care so much about you we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do. Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep all your appointments. We will provide you with a calendar at the front desk for all of your appointment times. With the exception of serious emergencies it is expected that you keep all your appointments. If you need to re-schedule an appointment we require 24 hours' notice.

In such a case, please call our office and arrange for a make-up appointment with our Front Desk. The make-up appointment needs to be in the same week, preferably the very next day. However, due to the popularity of our staff we cannot guarantee that we will be able to reschedule you to keep you compliant with your plan of care.

In an instance of cancellation, without 24 hours' notice, we reserve the right to charge you a $25.00 fee.

In an instance of a no-show you will be charged a $25.00 fee.

In instances of repeated noncompliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

Please sign below, stating that you read this policy and will adhere to these expectations.

Signature:_____ **Date:**_____

Galloway Therapy, PLLC

Appt *Date:* _____ **Time:** _____ **Requested: Physical Therapy Aquatic**

Who referred you to us? _____

Was this the first time you heard of Galloway Therapy? YES NO

If no where? _____

PATIENT INFORMATION

Patient Name: _____

Date of Birth: _____ **SSN:** _____

Address: _____ **Apt #** _____

City _____ **State** _____ **Zip** _____

Sex: M ___ F ___ Marital Status: Minor Single Widowed Married Divorced

Patient Employer / School: _____

Employer / School Address: _____

Responsible Party: _____

Relationship: _____

ACCIDENT INFORMATION

Is this condition due to an accident? YES NO

Date of Injury: _____

Type of Accident: AUTO WORK HOME OTHER

Have you made a report of your accident? YES NO

Insurance: _____

Attorney / Adjuster Name: _____

Phone: _____ **Claim #:** _____

Authorized # Visits: _____

Are you currently in Home Health? YES NO

CONTACT INFORMATION

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email Address: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone: _____

REFERRING PHYSICIAN

Name: _____

Phone: _____

PRIMARY CARE PHYSICIAN

Name: _____

Phone: _____

READ CAREFULLY:

I authorize Galloway Therapy, PLLC (and my representative thereof) to release any and all information that is necessary to any insurance company or companies, to my referring physician, family physician, and any physician to whom I may be referred. I agree this authorization will remain in effect until cancelled by me in writing. I authorize payment of benefits directly to Galloway Therapy, PLLC for services rendered and understand that I am responsible for any charges that are denied by my carrier. (If my coverage is with an HMO, I will assume responsibility for obtaining a referral from and/or number from my primary care physician and will be responsible for payment of services denied by my failure to obtain the referral. I am aware that this referral form and/or number is required prior to being examined.) I give my permission to be contacted or a message left at the phone numbers above regarding my appointment and/or treatment.

Patient Signature _____ Date: _____

PATIENT CONDITION

Reason for visit: _____

What treatment(s) have you already received for your condition?

Medications Surgery Physical Therapy Chiropractic Services None

Other: _____

Have you had a X-ray_____, MRI_____, CT-Scan_____

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of Pain: Please Circle

Sharp Dull Throbbing Numbness Aching Shooting Burning

Tingling Cramping Stiffness Swelling Other: _____

Activities or movements that are painful to perform:

SITTING STANDING WALKING BENDING LYING DOWN

WORK ACTIVITY: SITTING STANDING LIGHT LABOR HEAVY LABOR NONE

HEALTH HISTORY

FALLS: _____ **ALLERGIES:** _____

SURGERIES: _____

MEDICATIONS: _____ _____

_____ _____

_____ _____

_____ _____

_____ _____