HENNING & COLE'S PATIENT REGISTRATION FORM

Patient Name____Date of Birth ____________

Address: ___________________________City: _________________State ______Zip ______

Drivers License # ___________________ E-mail Address ___________________

Home Phone: (__) ____ - ________ Work Phone: (___)____-______

Employer_____________________________ Male ☐ Female ☐

Spouse's Name: _________________________________ Employer: ______________________________

Referring Physician _____________________________Telephone (___)____-______ Fax (___)____-____

Address: ____________________________________ City________________ State_____ Zip __________

Primary Physician: ______________________________ Telephone (___)____-______ Fax (___)____-____

Address: ____________________________________ City ________________ State ____ Zip __________

I Do ______ / Do Not _____ wish to have social or vocational rehabilitation services provided to me by Henning & Cole Therapy Associates, Ltd.

How did you learn of Henning & Cole? ____

INSURANCE INFORMATION

Primary Insurance ______________________________Plan Type________________________________

Policy Holder's Name _____________________________ Policy Holder Birth Date: ____________________

Policy Number ________________________________

Secondary Insurance ____________________________Plan Type________________________________

Policy Holder's Name _____________________________ Policy Holder Birth Date: ____________________

Policy Number ________________________________

Is this problem related to a-------Motor Vehicle Accident Yes / No or **Work Injury Yes / No**
If you answered Yes to either of the above, please complete the following insurance information..........

PIP or Worker's Compensation Carrier ________________________Phone #___________________________

Address _________________________________ City ______________________State ______ Zip ______

Adjustor's Name ____________________________ Claim #______________________ Date of injury________

Attorney name _____________________________ Telephone # __________________________

Address__________________________________ City ______________________State _____Zip________

CONSENT & ASSIGNMENT FORM

PLEASE READ BEFORE SIGNING

*****Medical Records Release Authorization*****

I hereby authorize Henning & Cole Therapy Associates, Ltd. to copy and transmit to the person(s) named below any and all medical records whatsoever, pertaining to my treatment by Henning & Cole Therapy Associates, Ltd.

Persons to whom the records may be released:

____________________________________ ____________________________________

____________________________________ ____________________________________

*****Authorization for the Treatment of Minors*****

I hereby authorize Henning & Cole Therapy Associates, Ltd. to perform Physical, Occupational or Speech Therapy on the minor named herein ____________________________of the parent or guardian named herein __________________________.

*****Medicare Authorization*****

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare Program or its intermediaries or carriers or to the Professional Standards Review Organization any information needed for this or a related Medicare claim. I request payment of authorized benefits be made on my behalf.

*****Managed Care*****

I understand that, without an authorization/referral form from my HMO/PPO/etc., I will be financially responsible for charges I incur.

*****Attorney Payment Authorization*****

I authorize and direct my attorney to deduct from the proceeds of my recovery from a third party, as a result of injuries stained by me, such amounts necessary to pay Henning & Cole and satisfy their total bill. I further authorize and direct my attorney to pay the sum directly to Henning & Cole Therapy Associates, Ltd. at the time of receipt of compensatory monies from a third party. I understand that I remain personally liable for payment of the total bill for professional services rendered to me and for related medical expenses, even if a settlement of judgement is not obtained.

*****Financial Policy*****

I certify that the information provided is correct. I understand that I am personally responsible to pay all charges for services rendered to me. I authorize payment for these services to be paid directly to Henning & Cole Therapy Associates, Ltd.

We must emphasize that as providers, our relationship is with you. *Your insurance is a contract between you, your employer and the insurance company.*

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to promptly contact our billing department for assistance in the management of your account, 410-683-9900.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you.

____(SEAL) ______________________

X Signature of Patient or Responsible Party Date

____ ______________________

X Witness Date

HENNING & COLE THERAPY ASSOCIATES LTD.

SUMMARY OF NOTICE OF PRIVACY PRACTICES

The following information is a summary of the **NOTICE OF PRIVACY PRACTICES**, which is posted in the office, in full text. **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.**

We are required by law to maintain the privacy of your medical information. We must provide you with a copy of this notice. We must follow the terms of this notice. If the notice is changed in any material way, a revised notice will be available upon request.

We will use your medical information for **Treatment.** For example, a therapist who is providing your care will report any changes in your condition to your doctor. We will use your medical information for **Payment.** For example, we may need to give your insurance plan information about your diagnosis, treatment and supplies used. We will use your medical information for **Health Care Operations.** For example, we may use your medical information to evaluate our services. We may contact you at any phone number or address you have provided to us to remind you of an appointment or other health care matters or to obtain payment for our services.

We may use your name and address for fund raising activities. We may use and disclose your medical information to inform you of treatment alternatives or other health related benefits and services. We may disclose your medical information to family members or others who are involved in your care or payment for that care. If we have a patient directory, we will include information about you in that directory. You must notify Our Designee in writing if you do not want us to communicate with you in any of these ways.

We may use your medical information for any uses that are required or permitted by law.

Other uses and disclosures will be made only with your written authorization. You may cancel an authorization at any time by notifying Our Designee in writing.

You have the following rights: **Right to privacy notice; Right to request restrictions on uses and disclosures of your medical information; Right to receive confidential communications; Right to inspect and copy your medical information; Right to request an amendment to your medical information; and Right to an accounting of disclosures of your medical information.**

If you feel that your privacy rights have been violated, please contact the individual listed at the end of this notice immediately or the U.S. Secretary of Health and Human Services.

Contact Information. Our Designee Lynda who can be contacted at:(410) 683-9900.

#639037

Acknowledgement of Receipt of Privacy Notice in Combination with Voluntary Consent

Acknowledgement:

As a patient of Henning & Cole Therapy Assoc. Ltd. (H&C) I have been provided with its **Notice of Privacy Practices** which describes how medical information about me may be used or disclosed and informs me of my individual privacy rights.

I acknowledge that I have received the Notice of Privacy Practices and understand how medical information about me may be used, the duties of H&C and my rights to privacy protection and access to my medical information. I understand that Our Designee is available to answer any questions that I may have regarding issues of privacy.

Consent:

I give consent for medical information about me to be used and disclosed for purposes of treatment, payment or health care operations. I understand that the privacy regulations allow H&C to use or disclose my medical information for these purposes and that my consent is not required. H&C is obtaining my consent to provide additional assurance regarding the privacy of my medical information.

I understand that I have the right to make a request to revoke this consent and instead request a restriction on the use of my medical information at any time. I further understand that H&C may choose not to agree to the request for a restriction on the uses or disclosures of my medical information for purposes of treatment, payment or health care operations.

To make a request to revoke my consent I must complete and sign a " Request to Restrict Uses and Disclosures of Protected Health Information " form and return it to Our Designee. I may obtain a copy of the form from Our Designee at 10 Warren Rd., Suite220: Cockeysville, Md. 21030. 410-683-9900.

_______________________________________ _______________________
Signature of Patient or Personal Representative Date

____
Written name of Patient or Personal Representative

____
Description of Personal Representative's authority to act on Patient's behalf

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