**Reynolds & Associates Physical Therapy, Inc.**
11312 US 15-501 North, Suite 401
Chapel Hill, NC 27517-6377
*Located in the back of Chatham Crossing Shopping Center*

**(919) 933-1110**
Fax: (919) 933-1150
ReynoldsPT@bellsouth.net
ReynoldsAndAssociatesPT.com


# NEW PATIENT REGISTRATION

ASSIGNED TO: _______________ APPT DATE: _____/_____/______

| PATIENT INFORMATION | | | | | | | |
|---|---|---|---|---|---|---|---|
| LAST NAME | FIRST | MI | DATE OF BIRTH / / | SOCIAL SECURITY NUMBER | | | SEX |
| HOME ADDRESS | | CITY | | | STATE | ZIP CODE | |
| HOME PHONE ( ) | CELL PHONE ( ) | | WORK PHONE ( ) | | | | |
| MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ OTHER | | EMPLOYMENT STATUS ☐ EMPLOYED ☐ RETIRED ☐ STUDENT ☐ OTHER | | | | | |
| If you would like a reminder call for future appointments, what number would you like us to call? PHONE NUMBER ( ) ☐ NO REMINDER CALL | | | | | | | |
| E-MAIL ADDRESS | | | | | | | |

| CARE PROVIDER INFORMATION | | |
|---|---|---|
| REFERRING PHYSICIAN | CLINIC NAME | PHONE NUMBER |
| PRIMARY PHYSICIAN | CLINIC NAME | PHONE NUMBER |

| INSURANCE INFORMATION | |
|---|---|
| PRIMARY INSURANCE CARRIER | PATIENT RELATIONSHIP TO POLICY HOLDER: ☐ SELF ☐ SPOUSE ☐ DEPENDENT ☐ OTHER |
| SECONDARY INSURANCE CARRIER | PATIENT RELATIONSHIP TO POLICY HOLDER: ☐ SELF ☐ SPOUSE ☐ DEPENDENT ☐ OTHER |

| EMERGENCY CONTACT | | |
|---|---|---|
| NAME | PHONE # ( ) | RELATIONSHIP TO PATIENT: ☐ PARENT ☐ SPOUSE ☐ OTHER |

| RESPONSIBLE PARTY (if not patient) / LEGAL GUARDIAN INFORMATION (if under 18) | | | | | | | |
|---|---|---|---|---|---|---|---|
| LAST NAME | FIRST | MI | DATE OF BIRTH / / | SOCIAL SECURITY NUMBER | | | SEX |
| HOME ADDRESS | | CITY | | | STATE | ZIP CODE | |
| PHONE NUMBER ( ) | CELL PHONE ( ) | | WORK PHONE ( ) | | | | |

Thank you for allowing us the opportunity to serve you. Please let us know if you have questions.

**Reynolds & Associates Physical Therapy, Inc.** **(919) 933-1110**
11312 US 15-501 North, Suite 401 Fax: (919) 933-1150
Chapel Hill, NC 27517-6377 ReynoldsPT@bellsouth.net
*Located in the back of Chatham Crossing Shopping Center* ReynoldsAndAssociatesPT.com

# NOTICE OF POLICIES & CONSENTS

Patient's Full Name Date of Birth / /

**CONSENT TO TREATMENT**
I do hereby consent to such treatment by the authorized personnel of Reynolds & Associates Physical Therapy Inc. as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment except acts of negligence.

**ASSIGNMENT OF BENEFITS**
I hereby assign all medical benefits to which I am entitled to Reynolds & Associates Physical Therapy, Inc. in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid directly by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits.

**CONSENT TO RELEASE OF MEDICAL RECORD INFORMATION**
I grant permission for Reynolds & Associates Physical Therapy, Inc. to obtain information from my physician and other medical professionals as it relates to my treatment.

**NOTICE OF INFORMATION PRACTICES (HIPAA)**
I have received, read and fully understand Reynolds's and Associates Physical Therapy, Inc.'s Notice of Information Practices. I understand that Reynolds and Associates Physical Therapy, Inc. 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 Reynolds & Associates Physical Therapy, Inc. will consider the request for restrictions on a case by case basis, but does not have to agree to requests for restrictions.

**DESIGNATED INDIVIDUAL(S) AUTHORIZATION (Optional)**
I authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations at Reynolds & Associates Physical Therapy, Inc. I understand the identities of designated parties must be verified before the release of any information.

Authorized Designee ____________________________________________ Relationship ___________________________

Authorized Designee ____________________________________________ Relationship ___________________________

**PATIENT INFORMATION CONSENT**
I hereby consent to the use and disclosure of my personal health information for purposes for purposes as noted in Reynolds and Associates Physical Therapy Inc.'s Notice of Information practices. I understand I retain the right to revoke this consent by notifying the practice in writing at any time.

- **Verification of coverage is not a guarantee of benefits.** We will file with your insurance company (if applicable). Actual plan coverage and benefit payment is determined when the claim is received and processed by your insurance company. You will be held responsible for any difference not paid by your insurance(s).
- **Please be aware that copayments, coinsurances or deductibles are due at the time services are rendered.** If special arrangements need to be made, please discuss them in advance. If you cannot pay at the time of service, we will gladly reschedule your appointment for you.
- **If you cannot keep your appointment for any reason, please call 48 hours prior to your appointment.** If you cancel the day of your appointment or if you do not show, a $25 cancellation fee may be applied. These charges will not be billed to nor paid by your insurance. If you cancel at least 48 hours ahead of your appointment, you will not be billed a cancellation fee. Additionally if you have multiple cancellations and/or no shows we may discharge you from physical therapy services and notify your doctor.
- **All supplies are payable at the time of service.** We will not bill your insurance company for supplies.
- **There will be a $25 charge for all returned checks.**

A copy of this assignment shall be considered as effective and valid as the original.

**By my signature below, I certify that I have read, understand, and agree to each of the above statements.**

_______________________________________________ ______________________________

Signature (Patient and/or parent or legal guardian) Date

**Reynolds & Associates Physical Therapy, Inc.**
11312 US 15-501 North, Suite 401
Chapel Hill, NC 27517-6377
*Located in the back of Chatham Crossing Shopping Center*

**(919) 933-1110**
Fax: (919) 933-1150
ReynoldsPT@bellsouth.net
ReynoldsAndAssociatesPT.com

# NOTICE OF PATIENT INFORMATION PRACTICES

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

## REYNOLDS & ASSOCIATES PHYSICAL THERAPY, INC. LEGAL DUTY

Reynolds & Associates Physical Therapy, Inc. 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

Reynolds & Associates Physical Therapy, Inc. 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, Reynolds & Associates Physical Therapy, Inc. may use your personal health related 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. We also provide information when required by law.

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

Reynolds & Associates Physical Therapy, Inc. may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of our facility. 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 purposes.

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. Reynolds & Associates Physical Therapy, Inc. will consider all such requests on a case-by-case basis, but the Company is not legally required to accept them.

## CONCERNS AND COMPLAINTS

If you are concerned that Reynolds & Associates Physical Therapy, Inc. 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 let the administrative staff know. You may also send a written complaint to the US Department of Health and Human Services.

**EVERY PATIENT MUST BE OFFERED A COPY OF THIS FORM**