FOOTHILLS SPORTS MEDICINE AND REHABILITATION
PATIENT REGISTRATION FORM

Please Print

Patient Name: _____ Patient Social #: _____

Gender: [ ] Male [ ] Female Birth Date: _____ Age: _____

Address: _____ City, State, Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Authorization to leave voice message, please initial _____ Email: _____

Parent/Guardian: _____ Parent/Guardian Social #: _____

Relationship to Patient: _____ Parent/Guardian Birth Date: _____

Referring Physician: _____ Primary Physician: _____

Emergency Contact: _____ Relationship/Phone: _____

Employer/School/Team Name: _____

How did you hear of Foothills Sports Medicine and Rehabilitation?

[ ] Referred by Doctor [ ] Friend or Family [ ] Social Media/Online [ ] Other:_____

Insurance Information (*To be completed even if insurance card on file)*

Primary Insurance	**Secondary Insurance**
Insurance Co Name: _____	Insurance Co Name: _____
Policy Holder: _____	Policy Holder: _____
Policy Holder Birth Date: _____	Policy Holder Birth Date: _____
Relationship to Patient: _____	Relationship to Patient: _____

AUTHORIZATION TO RELEASE PATIENT INFORMATION: I hereby authorize Foothills Sports Medicine and Rehabilitation to release any personal health information (PHI) required in the course of my examination or treatment to the above stated insurance company, or their affiliates.

Signed (Patient or guardian)_____ Date_____

AUTHORIZATION TO PAY: I hereby authorize insurance payment directly to **Foothills Sports Medicine and Rehabilitation, Billing Department, 15410 S. Mountain Pkwy. Suite 112, Phoenix, AZ 85044** for medical services rendered. I understand that I am financially responsible for the charges not covered by my insurance. In the event of default, I promise to pay collection costs and reasonable fees as may be required to obtain collection of this account.

Signed (Patient or guardian)_____ Date_____

FOOTHILLS
SPORTS MEDICINE
PHYSICAL THERAPY

ELECTRONIC COMMUNICATION CONSENT

Patient Name: _____

Email: _____

Cell Phone: _____

Appointment Reminders
Complete this form and sign below to give your permission for Foothills Sports Medicine to provide automatic appointment reminder service by email **OR** by cell phone text message.

☐ E-MAIL OPTION: Foothills Sports Medicine may send email messages to confirm my upcoming appointments.

OR

☐ TEXT OPTION: Foothills Sports Medicine may send cell phone text messages* to confirm my upcoming appointments. **Normal text messaging rates may apply.*

Please circle your cell phone carrier

ALLTel	Metrocell	T-Mobile
AT&T	MetroPCS	US Cellular
Boost Mobile	Nextel	Verizon
Cingular	Quest	Virgin Mobile
Cricket Wireless	Sprint PCS	

Text Message Surveys
In an effort to provide the highest possible quality of care, we will send text message surveys regarding your experience. You may opt-out at any time by replying “STOP” to any text you receive.

Join our Mailing List
Stay connected with all of the latest updates from Foothills Sports Medicine Physical Therapy. By providing your email address, you agree to receive periodic updates from Foothills Sports Medicine Physical Therapy. You may opt-out at any time by unsubscribing via the link at the bottom of every email.

Signature: _____ Date: _____

FOOTHILLS SPORTS MEDICINE AND REHABILITATION
NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION, INCLUDING HOUSE BILL 2045. PLEASE REVIEW IT CAREFULLY.

FOOTHILLS SPORTS MEDICINE & REHABILITATION, INC.'S LEGAL DUTY

Foothills Sports Medicine & Rehabilitation, Inc. is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow these practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Foothills Sports Medicine & Rehabilitation, Inc. uses your personal health information primarily for treatment; obtaining payment of treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Foothills Sports Medicine & Rehabilitation, Inc. may use your personal health 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.

Foothills Sports Medicine & Rehabilitation, Inc. may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Foothills Sports Medicine & Rehabilitation, 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.

Foothills Sports Medicine & Rehabilitation, Inc. may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the clinic and will be provided to you on your next visit. 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 information 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. Foothills Sports Medicine and Rehabilitation will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Foothills Sports Medicine & Rehabilitation, 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 contact the following person:

Cheri Anguis
canguis@foothillsrehab.com
480.689.5520

You may also file a complaint with the Department of Health and Human Services via mail, fax, email, or the OCR Complaint Portal. Additional information can also be found on their website at www.hhs.gov/ocr/hipaa/.

You will not be retaliated against for filing a complaint.

HOUSE BILL 2045

Effective December 31, 2013, in accordance with the Arizona House Bill 2045 which requires healthcare providers who are owners or employees of a legal entity with three or more licensed healthcare providers to post their direct pay prices for their 25 most commonly provided services online or make them available upon request. The bill specifies how services are to be identified, how often the list is to be updated and the timeframe from which the list is to be determined.

HB 2045 also requires healthcare providers to obtain a person's signature on a notice before accepting direct payment from that person if the healthcare provider is contracted as a network provider for a healthcare system in which the person is an enrollee. For more information about House Bill 2045, please visit the website of the Arizona State Legislature, azleg.gov. You may search for the bill using their Bill Number Search. All patients or their guardians must read and acknowledge the following guidelines.

MEMBER DIRECT PAYMENT NOTIFICATION – PROVIDER

Arizona state constitution permits you to pay a healthcare provider directly for health care services. Before you make any agreement to do so, please read the following important information.
If you have active health insurance coverage and your healthcare provider is contracting with your health insurance provider, the following guidelines apply:

1. You may not be required to pay the healthcare provider directly for the services covered by your health insurance plan, except for the cost-share amounts that you are obligated to pay under your plan; such as co-payments, co-insurance, and deductible amounts.
2. Your healthcare provider's agreement with your health insurance plan may prevent the healthcare provider from billing you for the difference between the healthcare providers billed charges and the amount allowed by your health insurance plan for covered services.
3. If you pay directly for health care service(s), your healthcare provider is not responsible for submitting claim documentation to your health insurance plan. Before paying your claims, your health insurance plan may require you to provide information and submit documentation necessary to determine whether the services are covered under your health insurance plan.
4. If you do not pay directly for health care service(s), your healthcare provider may be responsible for submitting claim documentation to your health insurance plan for the health care service(s).

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Foothills Sports Medicine & Rehabilitation, Inc.'s Notice of Information Practices.

- I understand that Foothills Sports Medicine & Rehabilitation, 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 Foothills Sports Medicine & Rehabilitation, Inc. will consider requests for restriction on a case by case basis, but does not have to agree to request for restrictions.
- I hereby consent to the use and disclosure of my personal health information for purposes as noted in Foothills Sports Medicine & Rehabilitation, Inc.'s Notice of Information Practices.
- I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.
- Your signature below acknowledges that you received House Bill 2045 notice before paying this provider for healthcare service(s).

Patient Name: _____

Signature of responsible party: _____

Printed Name of signer: _____

Date: _____

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby 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 related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.
Authorized Designees:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient Name: _____

Signature of responsible party: _____

Printed Name of signer: _____

Date: _____