Patient Information (Please Print)

Name _____ Date of Birth_____

Address _____

City, State, Zip _____Referring MD _____

Phone # _____ Alt. # _____

Employer _____ Work #_____

SS # _____ Email _____

Type of Insurance

( ) Work Comp ( ) Medicare ( ) BCBS ( ) Other _____

Primary Insurance Contract # _____ Group _____

Name & DOB of Contract Holder _____

Secondary Insurance Contract #_____ Group _____

Name & DOB of Contract Holder _____

How did you hear of Wilhoite Physical Therapy?

( ) Physician ( ) Friend / Relative ( ) Newspaper ( ) Radio ( ) Other _____

Do we have permission to…

- Leave a message on your answering machine at home? ( ) yes ( ) no
- Leave a message at work? ( ) yes ( ) no
- Discuss your medical condition with another member of your home?

( ) Spouse ( ) Mother ( ) Father ( ) Children ( ) Other _____

Emergency Contact: _____

Name Phone

Authorization and Assignment

I hereby authorize Wilhoite & Associates to furnish all information needed to my insurance carrier concerning my illness and treatments. I also assign Wilhoite & Associates all payments for physical therapy services rendered to my dependent or myself. I understand that I am responsible for any amount not covered by my insurance carrier. I agree to pay all costs of collections, including but not limited to, a reasonable attorney's fee should this account be placed with an attorney for collection. I am responsible for my deductible not met at the time of treatment. I have read and fully understand the above information.

_____ _____

Patient, Parent, or Legal Guardian Date

Medical History

Heart Conditions	**Yes**	**No**
Heart Attack	_____	_____
Heart Murmur	_____	_____
Open Heart Surgery	_____	_____
Other Heart Conditions		

_____

_____

Lung Conditions		
Asthma	_____	_____
Emphysema	_____	_____
Shortness of Breath	_____	_____
Other Lung Conditions		

_____

_____

Blood Pressure		
High Blood Pressure	_____	_____
Low Blood Pressure	_____	_____

Other		
Arthritis	_____	_____
Back Problems	_____	_____
Diabetes	_____	_____
Fainting	_____	_____
Gout	_____	_____
Head Injury	_____	_____
Heartburn	_____	_____
Kidney Problems	_____	_____
Lower Body Problems	_____	_____
Multiple Sclerosis	_____	_____
Muscular Dystrophy	_____	_____
Neck Problems	_____	_____
Pacemaker	_____	_____
Polio	_____	_____
Upper Body Problems	_____	_____

Current Pain Rating

1 2 3 4 5 6 7 8 9 10

List current Medications: _____

_____

_____

_____

Wilhoite & Associates, P.C.

Physical Therapists

Patient Compliance Form

Welcome to our clinic. We look forward to working with you to help resolve your health care needs. In order to allow for a smooth process, the staff has a few expectations.

To maximize the efforts of the treatment you will receive, please:

Show up on time. If you are late, the therapist reserves the right to shorten your treatment session or cancel/reschedule it.

Avoid cancellations. Even when a cancellation is unavoidable, please give a 24-hour notice, or in case of an emergency, the most notice possible. If treatments are cancelled too often or there are frequent no-shows, your therapist reserves the right to charge a fee of $20.00 and/or discontinue your care. Be aware that this may have a negative impact with your insurance carrier or worker's compensation benefits.

Follow the directions of your therapist. As a very important part of your care, your therapist will give you a list of exercises to do at home, Your therapist may also give you additional instructions that you will need to follow in order to maximize your recovery. A positive outcome for you depends on your active participation in your rehabilitation program. Not complying with these may negatively affect the outcome of your treatment.

Thank you so much for complying with these requests. As stated, our staff makes these requests to assure effective and timely care for you and other patients.

I agree with this policy,

_____ _____

Patient Signature Date

Wilhoite & Associates, P.C. **David L. Wilhoite, P.T.**
1617 Leighton Ave., Anniston, AL 36207 651 Snow St., Oxford, AL 36203
Effective Date of this Notice: April 1, 2003

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)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In treating you, we will create medical records about you, and will comply with all laws regarding confidentiality of those records. every member of our staff is trained and informed on confidentiality and will follow this notice, including physicians, nursing staff, and office personnel. We will take all precautions to restrict access to confidential records by unauthorized persons.

Ways we may use your IIHI:

Treatment. Information is needed to properly evaluate, diagnose and treat you. It is required in order to prescribe medication, order laboratory tests, refer you for further treatments, evaluations, and discuss findings with you, your other physicians & caretakers, etc. and family, if you desire. We will remind you of appointments.
Payments. If we file insurance for you, we will provide information to your insurer(s), or other 3rd parties who may be paying on your behalf, so that we may obtain payment for our services. Statements of any possible outstanding bills will be sent to you, and may contain medical information.
Health Care Operators. Our practice may use and disclose your IIHI to operate our business, such as to evaluate quality of care given to you.
Other Reasons. Include disclosures required by federal, state or local law, certain special circumstances such as public health risks, health oversight activities, lawsuits, etc. This can include disclosures to medical examiners or coroners, military authorities, police investigations and the like.

YOUR RIGHTS REGARDING YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI)

Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
Requesting Restrictions. You have the right to request a restriction in our use or disclose of your IIHI for treatment, payment of health care operations, and, to only certain individuals. **We are not required to agree with your request.** Your request must be in writing in a clear & concise manner to our privacy officer given below.
Inspection and Copies. You have the right to inspect & obtain copies of your IIHI that may be used to make decisions about you y submitting your request in writing to the privacy officer. We may change fees for the costs involved, and in certain limited circumstances deny requests. You may request a review of your denial.
Amendment. You may request, in writing, an amendment of your health information if you believe it is incorrect or incomplete, for as long as the information is kept by for our practice. A request MUST provide a reason that supports your request We will not amend something that, in our opinion, is accurate and complete.
Accounting of Disclosures. You have the right to request an "account of disclosures", a list of certain non-routine disclosures our practice might have made of your IIHI for non-treatment or operation purposes. These requests must be in writing & must state a time period, which may not be longer than 6 years from the date of disclosure and may not include dates before April 14, 200. Multiple requests within a 12-month period will be charges a fee.
Right to a Paper Copy of This Notice. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the Privacy Officer listed below.
Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Privacy Officer listed below. You will not be penalized for filing a complaint.
Right to Provide and Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. And authorization you provide to us regarding the use and disclosure of your IIHI that are not identified by this notice or permitted by applicable law,. Any authorization for uses and disclosure of your IIHI may be revoked at any time **in writing**. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note we are required to retain records of your care.

CHANGES TO THIS NOTICE: We reserve to make any changes to this notice, but a current copy will always be posted and available.

Any complications or requests are to be directed to our PRIVACY OFFICER:
James Askew, Administrator
Wilhoite & Associates, P.C.
1617 Leighton Avenue Anniston, Alabama 36207

I acknowledge, by signing below, that I have received the *Notice of Privacy Practices and Individual Rights*

_____ _____
Patient or Patient's Guardian/Representative **Date**