Hands-On Diagnostics of Alaska
1200 Airport Heights Ste 170
Anchorage, AK 99508
Phone (907) 290-4760 * Fax (907) 562-2128

First Name _____ Last Name _____ MI ___ Social Security # _____

Nick-name _____

O Male
O Female
Birth Date _____

O Married
O Single
O Other

Select One: O FT Student O PT Student O FT Employed O PT Employed O Unemployed

Physical Address: _____

City/St/Zip: _____

Mailing Address (if different): _____

City/St/Zip: _____

Email Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Fax Number _____

Spouse / Guardian Information

Name: _____

Relationship: _____

Address: _____

City/St/Zip: _____

Phone Number: _____

Emergency Contact information

Name: _____

Relationship: _____

Address: _____

City/St/Zip: _____

Phone #: hm/cell/wk _____

Person Responsible for Bill

Name: _____

Relationship: _____

Address: _____

City/St/Zip: _____

Phone Number: _____

Employer

Employer: _____

Occupation: _____

Address: _____

City/St/Zip: _____

Phone Number: _____

Is this a job related injury/personal injury? O Yes O No

Date of Injury: _____ Employer (if applicable): _____

Insurance: _____ Claim #: _____

Claim Adjustor Name: _____ Phone #: _____

Is there an attorney involved? _____ If so, Name/Phone #: _____

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REFERRING PHYSICIAN

Name:_____ Clinic:_____ Phone:_____

Primary Insurance? O Yes O No

Company:_____

Policy #: _____

Group #: _____

Patient's relationship to Subscriber [ ] Self [ ] Spouse
[ ]Parent [ ] Other _____
If other than self:
Subscribers Name: _____
DOB_____ SS#_____

Secondary Insurance? O Yes O No

Company:_____

Policy #: _____

Group #: _____

Patient's relationship to Subscriber [ ] Self [ ] Spouse
[ ]Parent [ ] Other _____
If other than self:
Subscribers Name: _____
DOB_____ SS#_____

I understand that I am responsible for my medical charges and I agree to pay in a timely manner my deductible, co-insurance or co-payment and any charges not reimbursed by my insurance carrier. I authorize Hands-On Diagnostics of Alaska/Wise Physical Therapy to bill my insurance company and I authorize payment from the insurance carrier directly to Hands-On Diagnostics of Alaska/Wise Physical Therapy. I authorize Hands-On Diagnostics of Alaska/Wise Physical Therapy to release medical or other information necessary to process this claim.
I understand and agree that health and accident insurance policies are an agreement between an insurance company and myself. I understand that some insurance companies have deductibles, co-pays, and/or require medical or administrative preauthorization for treatment. *I understand that I am responsible for knowing and meeting the requirements of my insurance plan*. Hands-On Diagnostics of Alaska/Wise Physical Therapy is not responsible for incorrect information given by my insurance carrier regarding my benefits.
In the event of my default, I agree that I will be responsible for all costs of collecting amount owed, including but not limited to court costs, collections agency fees, and attorney fees.
(The above may not apply for those patients that are considered Worker's Compensation or who have benefits with a balance billing contract, such as an HMO. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.)

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Printed Name_____

Signature _____ **Date** _____
(Patient/Guardian/Responsible Party)

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HIPAA Compliance Policy

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you. Please review it carefully.

1. Get an electronic or paper copy of your medical record:
    a. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
    b. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
2. Ask us to correct your medical record:
    a. You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
    b. We may say "no" to your request, but we'll tell you why in writing within 60 days.
3. Request confidential communications
    a. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
    b. We will say "yes" to all reasonable requests.
4. Ask us to limit what we use or share:
    a. You can ask us not to use or share certain health information for treatment, payment, or our operations.
    b. We are not required to agree to your request, and we may say "no" if it would affect your care.
    c. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
    d. We will say "yes" unless a law requires us to share that information.
5. Get a list of those with whom we've shared information:
    a. You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
    b. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
6. Get a copy of this privacy notice:
    a. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
7. Choose someone to act for you
    a. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
    b. We will make sure the person has this authority and can act for you before we take any action. File a complaint if you feel your rights are violated
    c. You can complain if you feel we have violated your rights by contacting us using the information at the top of this page.
    d. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or

visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

e. We will not retaliate against you for filing a complaint.

8. For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:
    a. Share information with your family, close friends, or others involved in your care
    b. Share information in a disaster relief situation
    c. Include your information in a hospital directory
    d. Contact you for fundraising efforts
9. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. In these cases, we never share your information unless you give us written permission:
    a. Marketing purposes
    b. Sale of your information
    c. Most sharing of psychotherapy notes
10. In the case of fundraising:
    a. We may contact you for fundraising efforts, but you can tell us not to contact you again.
11. How do we typically use or share your health information? We typically use or share your health information in the following ways.
    a. We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.
    b. We can use and share your health information to run our practice, improve yourcare, and contact you when necessary. Example: We use health information about you to manage your treatment and services.
    c. We can use and share your health information to review the competence or performance of those who render healthcare services to you. Example: We use health information about you to monitor the quality of healthcare treatment and services provided to you.
    d. We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for yourservices.
12. How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes.

    For more information see:
    www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.
13. We can share health information about you for certain situations such as:
    a. Help with public health and safety issues
    b. Preventing disease
    c. Helping with product recalls
    d. Reporting adverse reactions to medications

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e. Reporting suspected abuse, neglect, or domestic violence
f. Preventing or reducing a serious threat to anyone's health or safety
g. Do research
    i. We can use or share your information for health research.
h. Comply with the law
    i. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
i. Respond to organ and tissue donation requests
    i. We can share health information about you with organ procurement organizations.
j. Work with a medical examiner or funeral director
    i. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
k. Address workers' compensation, law enforcement, and other government requests

14. **We can use or share health information about you:**
    a. For workers' compensation claims
    b. For law enforcement purposes or with a law enforcement official
    c. With health oversight agencies for activities authorized by law
    d. For special government functions such as military, national security, and presidential protective services
15. **We can share health information about you in response to a court or administrative order, or in response to a subpoena.**
16. **We are required by law to maintain the privacy and security of your protected health information.**
17. **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**
18. **We must follow the duties and privacy practices described in this notice and give you a copy of it.**
19. **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date of this Notice: October 23, 2018

I _____ acknowledge that my signature below indicates that I have received this notice and have been given the opportunity to ask questions about the policies and procedures contained within.

_____ _____

Signature Date

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MEDICAL HISTORY

Allergies	O Yes O No	Dizzy Spells	O Yes O No	MRSA – Staph Infection	O Yes O No
Anemia	O Yes O No	Emphysema/Bronchitis	O Yes O No	Multiple Sclerosis	O Yes O No
Anxiety	O Yes O No	Fibromyalgia	O Yes O No	Muscular Disease	O Yes O No
Arthritis	O Yes O No	Fractures	O Yes O No	Osteoporosis	O Yes O No
Asthma	O Yes O No	Gallbladder Problems	O Yes O No	Parkinson's Disease	O Yes O No
Autoimmune Disease	O Yes O No	Headaches	O Yes O No	Rheumatoid Arthritis	O Yes O No
Cancer	O Yes O No	Hearing Impairment	O Yes O No	Seizures	O Yes O No
Cardiac Conditions	O Yes O No	Hepatitis	O Yes O No	Smoking	O Yes O No
Cardiac Pacemaker	O Yes O No	High Cholesterol	O Yes O No	Speech Problems	O Yes O No
Chemical Dependency	O Yes O No	High Blood Pressure	O Yes O No	Stroke	O Yes O No
Circulation Problems	O Yes O No	HIV/AIDS	O Yes O No	Thyroid Disease	O Yes O No
Currently Pregnant	O Yes O No	Incontinence	O Yes O No	Tuberculosis	O Yes O No
Depression	O Yes O No	Kidney Problems	O Yes O No	Vision Problems	O Yes O No
Diabetes	O Yes O No	Metal Implants	O Yes O No		

Describe any other conditions:

Fall History

Is the injury as a result of a fall in the past year? O Yes O No Date of Fall:_____

Two or more falls in the last year? O Yes O No Dates of Falls:_____

Surgical History

Body Region: _____ Surgery Type: _____Date of Surgery:_____

Body Region: _____ Surgery Type: _____Date of Surgery:_____

Body Region: _____ Surgery Type: _____Date of Surgery:_____

Body Region: _____ Surgery Type: _____Date of Surgery:_____

Body Region: _____ Surgery Type: _____Date of Surgery:_____

Current Medications: prescribed and over-the-counter

Drug: _____ Dosage: _____ Reason for Taking:_____

Drug: _____ Dosage: _____ Reason for Taking:_____

Drug: _____ Dosage: _____ Reason for Taking:_____

Drug: _____ Dosage: _____ Reason for Taking:_____

Drug: _____ Dosage: _____ Reason for Taking:_____

Printed Name_____

Signature_____ **Date** _____