



Damien Howell Physical Therapy

PATIENT REGISTRATION FORM

Patient's Name _____ O Male O Female
(First) (Middle Initial) (Last)

Address _____ City _____

State _____ Zip _____ Email _____

Home Phone _____ Work/Cell Phone _____

SSN _____ Date of Birth ____/____/____ Age _____

Employer _____ Address _____

Insured's Name _____ Date of Birth ____/____/____ SSN _____

Insured's Employer _____ Phone _____

Employer's Address _____

Date of Injury, if known _____ Referring Physician _____

Person who recommended our services if other than physician _____

Person to contact in case of emergency _____

Relationship _____ Work Phone _____ Home Phone _____

Nearest relative not living with you _____ Phone _____

Have you been a patient here before? ____ Have you had physical therapy or chiropractic in the past 12 months?

Is this Worker's Comp? ____ If yes, contact person at work _____ Phone _____

I desire that physical therapy services be provided to me and understand it will be my responsibility to pay for these services if my insurance does not pay or if my insurance benefits are paid to me inadvertently. I request that payment of authorized insurance benefits for services be preassigned to Damien Howell Physical Therapy.

I understand that any balance remaining on my account after 60 days from the date of service is subject to interest charges at the rate of 2% per month. I understand I am responsible for all registered mail fees, court costs, and attorney fees incurred as a result of collection efforts on this account.

Patient Signature _____ Date _____

Patient Representative/Legal Guardian, if applicable _____

**PROVIDER NOTICE
OF PRIVACY PRACTICES**

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.

Uses and Disclosures: We use health information about you for treatment, billing, and healthcare operations. Continuity of care is part of treatment and your records may be shared with other providers to whom you are referred. Information may be shared by paper mail, electronic mail, fax, or other methods. We may use or disclose identifiable health information about you without your authorization in several situations, but beyond those situations, we will ask for your written authorization before using or disclosing any identifiable health information about you.

Your rights: In most cases, you have the right to look at or get a copy of health information about you. If you request copies, we may charge you a fee. You also have the right to receive a list of certain types of disclosures of your information that we made. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information.

Our legal duty: We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and seek your acknowledgement of receipt of this notice. If we make a significant change in our policies, we will change our notice and post the new notice in the waiting area.

You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Complaints: If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request.

If you have any questions or complaints, please contact:
Privacy Officer: Damien Howell
Address: 1811 Huguenot Road
Suite 103
Midlothian VA 23113
Phone: (804) 594-0403

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Acknowledgement of receipt of Notice of Privacy Practices:
Please sign your name and print your name and date on this acknowledgement form.

Patient Signature: _____ Date: _____

Printed Name: _____

Patient Representative/Legal Guardian, if applicable: _____