

TMS Physical Therapy  
201-B Erie Street  
Grove City, PA 16127

P.T. \_\_\_\_\_

Diag: 1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

**Please Print**

Patient Name: \_\_\_\_\_ Social Security#: \_\_\_\_\_

Address: \_\_\_\_\_  
City State Zip

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F Marital Status: S M W D

Phone# \_\_\_\_\_ Cell Phone#: \_\_\_\_\_ email address: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Work/School Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Please list two emergency contacts outside of your residence:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Is this a worker's compensation injury? Yes/No Is this an Auto Accident? Yes/No

Claim#: \_\_\_\_\_ Date of Injury: \_\_\_\_\_ Phone#: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Subscriber: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Subscriber's date of birth: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Subscriber: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Subscriber's date of birth: \_\_\_\_\_

**I understand that I am ultimately responsible for payment of all services rendered, unless otherwise provided by law. This may include, but not limited to, *deductibles* and all *copays*. Payment is expected when services are rendered unless prior arrangements have been made.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Revised 6/09



**TMS PHYSICAL THERAPY**  
**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. **PLEASE REVIEW IT CAREFULLY.**

**TMS PHYSICAL THERAPY'S LEGAL DUTY**

**TMS Physical Therapy** 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**

**TMS Physical Therapy** 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, **TMS Physical Therapy** 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.

**TMS Physical Therapy** 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, **TMS Physical Therapy's** policy is to obtain your written authorization before disclosing your personal health information. If you provide us with written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

**TMS Physical Therapy** may change its policy at any time. When changes are made, a new Notice of Information Practices 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 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 purpose.

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. **TMS Physical Therapy** 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 **TMS Physical Therapy** 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 our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on **TMS Physical Therapy's** health information practices or if you have a complaint, please contact the following person:

I have read and fully understand **TMS Physical Therapy's** Notice of Information Practices. I understand that **TMS Physical Therapy** 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 **TMS Physical Therapy** will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in **TMS PHYSICAL THERAPY'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.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## **Cancellation/No Show Policy**

TMS Physical Therapy and Aquatic Therapy Center is initiating a Cancellation/No Show Policy

Here at TMS Physical Therapy we realize that once in a while circumstances require you to cancel or miss an appointment and we are happy to reschedule your appointment when this happens.

While canceling appointments can create scheduling problems, it also interrupts your rehabilitation program for your injury/condition. Frequent cancellations and no shows make our treatments less effective toward reaching your goals and the goals of your referring physician. Please attend all treatments, if possible, so that together we can reach your full potential and maximum recovery.

It is a fact that there are two reasons why patients have a better outcome from therapy – 1. regular attendance of physical therapy and 2. being compliant with home exercise program. Tim Schell, P.T. wants to say **thank you** for being conscientious about your therapy. Effective April 30, 2007 TMS Physical Therapy will be rewarding patients for attending their scheduled physical therapy visits. If you are scheduled for “x” number of visits per your plan of care, prescription or referral and you attend all “x” number of visits without a “no-show” (this does not include cancellations or rescheduled appointments) Tim Schell wants to reward you with a gift card from Sheetz.

As a courtesy to our staff and to all our patients and in order to better serve ALL of our patients, please call us at least 24 hours in advance with your cancellation. If you arrive at the wrong time for your appointment, we will make every effort to provide your entire treatment as long as we do not inconvenience those patients already scheduled for that day.

We are pleased that you chose TMS Physical Therapy and Aquatic Therapy Center for your physical therapy rehabilitation. Please partner with us to help make your recovery here at TMS a successful experience.

I have read and I do understand that I must cancel an appointment within 24 hours. I also understand that I may be entitled to a free gift for being compliant.

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Signed

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Date

# HOW DID YOU HEAR ABOUT TMS PHYSICAL THERAPY?

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

(Please check ONLY ONE that applies)

\_\_\_\_\_ I am a returning patient

\_\_\_\_\_ Doctor Referral

\_\_\_\_\_ Employer

\_\_\_\_\_ Mailing

\_\_\_\_\_ Health Club

\_\_\_\_\_ Insurance Company

\_\_\_\_\_ Newspaper

\_\_\_\_\_ Radio

\_\_\_\_\_ School

\_\_\_\_\_ Sign on building

\_\_\_\_\_ Computer

\_\_\_\_\_ Family or Friend referral

\_\_\_\_\_ Location

\_\_\_\_\_ Health Fair

\_\_\_\_\_ Other \_\_\_\_\_

**THANK YOU!**