

**PATIENT REGISTRATION**

PATIENT NAME: \_\_\_\_\_  
FIRST MI LAST

SOCIAL SECURITY #: \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ CIRCLE ONE: SINGLE MARRIED DIVORCED WIDOWED

EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

**EMERGENCY CONTACT**

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

REFERRING DOCTOR: \_\_\_\_\_ OFFICE LOCATION: \_\_\_\_\_

**INSURANCE INFORMATION**

PRIMARY CARD HOLDER: SELF \_\_\_\_\_ SPOUSE \_\_\_\_\_ OTHER \_\_\_\_\_

PRIMARY CARD HOLDER'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_ PHONE: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

SECONDARY CARD HOLDER'S NAME: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

RELEASE OF INFORMATION: I authorize the release of any medical information necessary to process my claims.

PAYMENT AUTHORIZATION: I hereby order and authorize insurance payments to be directed to Associated Therapeutics, Inc., 2704 Mineral Springs Avenue, Knoxville, TN 37917.

LAWSUIT LITIGATION: We do not accept law suit litigations.

I understand that should my insurance company deny or should a balance remain unpaid, I will be personally liable for payment of any such balance to Associated Therapeutics, Inc.

\_\_\_\_\_  
PATIENT SIGNATURE (Parent's signature if patient is a minor)

\_\_\_\_\_  
FOR OFFICE STAFF USE

\_\_\_\_\_  
DATE





2704 Mineral Springs Avenue □ Knoxville, Tennessee 37917 □ 865-687-4537 • www.associatedtherapeutics.com

Dear Patient:

Welcome to Associated Therapeutics, Inc. Our staff is dedicated to providing you with competent, individualized care. Our primary goal is to maximize your ability to function at home, in the work place, and in the community.

We have prepared this letter to help you understand your responsibilities as a patient at Associated Therapeutics, Inc. Please read them carefully.

**PATIENT RESPONSIBILITIES**

- I understand that it is my responsibility to be informed regarding my insurance coverage. This office encourages you to communicate with your insurance company regarding your coverage and your questions.
- I understand that Associated Therapeutics files my insurance as a courtesy to me. I understand that my bills will be filed one time to my insurance, with all necessary documentation. If after 60 (sixty) days this office has not received payment, I understand that it is my responsibility to make arrangements to pay my balance.
- I understand that it is my responsibility to make my co-payment (10%, 20%, etc. depending upon my insurance coverage) at each visit.
- I understand that any amount of my bill that remains unpaid, is denied for any reason, is applied to my deductible, and/or paid directly to me as my responsibility.
- I understand that should I fail to make arrangements to pay my balance, my account will be turned over to a collection agency.

My signature below indicates that I understand and agree to the above terms and that these terms are a condition to my treatment.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Thank you for allowing us to assist you in reaching your treatment goals. Our staff is here to serve, please feel free to call upon them.

Sincerely,

Andrew E. Smith, M.S., P.T.  
Co-owner

Thomas J. Kelly, P.T.  
Co-owner

**Associated Therapeutics, Inc.**  
**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.

**ASSOCIATED THERAPEUTICS, INC.'S LEGAL DUTY**

Associated Therapeutics, Inc. is required by law to protect the privacy of your protected health information, provide this notice about our information practices, and follow the information practices, effective April 1, 2003, that are described herein.

**USES AND DISCLOSURES OF HEALTH INFORMATION**

Associated Therapeutics, Inc. uses your protected health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities; and evaluating the quality of care that we provide. For example, Associated Therapeutics, Inc. may use your protected 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.

Associated Therapeutics, Inc. may also use or disclose your protected 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, Associated Therapeutics, Inc.'s policy is to obtain your written authorization before disclosing your protected 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.

We reserve the right to change our policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room 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 protected 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 protected health information for reasons other than treatment, payment, or other related administrative purposes.

## CONCERNS AND COMPLAINTS

If you are concerned that Associated Therapeutics, Inc. may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your protected health information, please contact our Privacy Officer 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 Associated Therapeutics, Inc.'s health information practices, or if you have a complaint, please contact:

**Thomas J. Kelly, PT**  
**Associated Therapeutics, Inc.**  
**2704 Mineral Springs Road**  
**Knoxville, TN 37917**  
**Telephone: 865-687-4537**  
**Fax: 865-687-5367**

## ASSOCIATED THERAPEUTICS, INC. PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Associated Therapeutics, Inc.'s Notice of Information Practices. I understand that Associated Therapeutics, Inc. may use or disclose my protected 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 protected health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Associated Therapeutics, Inc. will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge the use and disclosure of my protected health information for purposes as noted in Associated Therapeutics, Inc.'s Notice of Information Practices. I understand that I retain the right to revoke this acknowledgement by notifying the practice in writing at any time.

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Patient Name

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Patient Signature

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Date

I also authorize Associated Therapeutics, Inc. to use my protected health information for target marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

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