TOUCHSTONE REHABILITATION
Neurologic Therapy Specialists, LLC
5055 E. Washington Street #125 | Phoenix, Az 85034 | PH: 602.277.1073 FX: 602.277.1016
TAX ID: 205787714 NPI: 1386721512

PATIENT DEMOGRAPHIC INFO

Today's Date:

Is patient receiving HOME HEALTH CARE? []Y []N If so, what service? (nurse, therapist, aid)_____
What company? **THIS IS CRITICAL PRIMARILY FOR MEDICARE PATIENTS** ***Medicare won't pay if receiving Home Health***

PATIENT INFORMATION

Last name:	First Name:	MI:
Gender: []M []F	DOB:	Age:
Primary language: []English []Other *specify*		Race:
SSN:	Marital status: []S []M []W []D []Sep	
Local address:		
City:	State:	Zip:
Phone:		
Cell Phone:	Email:	
Permanent address:		
City:	State:	Zip:
Date of Injury/stroke:	Name of spouse/guardian:	
Type of Injury: []auto accident []fall []surgery related []sports []other []other accident []work related []none listed		
How did you hear about us/who referred you?		
EMERGENCY CONTACT:		Relationship:
Phone(s):		
PHYSICAN INFORMATION		
Referring physician:	Phone:	
Address:		Fax:
Primary Care physician:	Phone:	
Address:		Fax:
RESPONSIBLE PARTY NAME:		Phone:
Employer:		Occupation:
Address:		
Claim number:		

[] Demographics updated in WebPT [] eDoc [] T:patientrecords *DOCID:aliciafolder/demographicfrm*

PRIMARY INSURANCE		
Address:		
ID#	Group#	Policy#
Policy holder's name:		Relation to pt:
SSN:	DOB:	Employer:
Address *(if different from pt.)*		
Claim number:		
SECONDARY INSURANCE		
Address:		
ID#	Group #	Policy#
Policy holder's name:		Relation to pt:
SSN:	DOB:	Employer:
Address *(if different from pt.)*		
Claim number:		

ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE INFO

I authorize payment of my insurance benefits directly to Neurologic Therapy Specialists, LLC. I understand I am personally responsible for balance not paid by my insurance. I understand I am responsible to know my insurance benefits under my policy and payments for which I may be responsible.

X_____/_____/_____
Patient/Responsible party Date

I authorize Neurologic Therapy Specialists, LLC to release any medical records to myself or those clinicians necessary to assist with coordination of care or the processing of my claim. I also authorize Neurologic Therapy Specialists, LLC and the treating clinicians to communicate with other treating medical clinicians regarding my care. I acknowledge that I have been offered a copy of the Notice of Privacy Practices for Neurologic Therapy Specialists, LLC and have received one if I chose to have a copy.

I voluntarily consent to receive treatment for my condition according to my treatment plan. I have been informed by my therapist or physician about significant risks, benefits and alternatives to the procedures and have had my questions answered. I further understand that I may rescind this consent at any time and will be informed of the potential consequences of that decision.

X_____/_____/_____
Patient/Responsible party Date

TEXT & EMAIL REMINDERS

Touchstone Rehabilitation offers text and/or email reminders. Please complete the information below if you would like to be signed up for an appointment reminder.

Choose one:

[] Cell phone (text) _____/_____

[] Email _____

DISCLAIMER: Touchstone Rehabilitation is not responsible for any usage or data charges issued by your phone carrier. We will never share your information with anyone other than those involved in your treatment plan.

Signature: Patient/responsible party **X** Date:

Neurologic Therapy Specialists, LLC
5055 E. Washington St, Ste 125, Phoenix, Arizona 85034, 602-277-1073 phone, 602-277-1016 fax

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

In this document, "we" refers to Neurologic Therapy Specialists, LLC. "You" or"yours" refers to individual patients. We are required by federal law to protect the privacy of your individual health information (referred to in this notice as "Protected Health Information" or PHI). We are also required to provide you with this notice regarding our legal duties and privacy practices with respect to your PHI, and to abide by the terms of this notice.

We maintain medical information about you in the course of providing heath care services to you. We also hire business associates, such as a billing service and a transcription service, and bill third party payers, such as Medicare, in the process of providing and billing these services. These business associates also receive and maintain medical information about you.

Purposes for which we may use or disclose medical information about you without your consent or authorization.

We may use and disclose medical information about you for the following purposes:

- **Health Care Providers' Treatment Purposes**. For example, to communicate with your doctor we may disclose medical information about you.
- **Payment.** For example, we may use or disclose medical information about you to pay claims for covered health care services or to provide eligibility information to your doctor when you receive treatment
- **Health Care Operations**. For example, we may use or disclose medical information about you for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of contracts.
- **Health Services**. For example, we may use medical information about you to contact you to give you information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- **As Required By Law**. For example, we must allow the U.S. Department of Health and Human Services to audit our records. We may also disclose medical information about you as authorized by and to the extent necessary to comply with workers' compensation or other similar laws.
- **To Business Associates**. We may disclose medical information about you to business associates we hire to assist us in your care. Each business associate must agree in writing to ensure the continuing confidentiality and security of medical information about you.

We may also use and disclose medical information about you as follows:

- To comply with legal proceedings, such as a court or administrative order or subpoena
- To law enforcement officials for limited law enforcement purposes.
- To your personal representatives appointed by you or designated by the applicable law.
- For research purposes, as long as certain privacy-related standards are satisfied.
- To a governmental agency authorized to oversee the health care system or government programs.
- We may disclose to one of your family members, to a relative, to a close personal friend, or to any other person identified by you, PHI that is directly relevant to the person's involvement with your care or payment related to your care.

Authorizations: Uses and Disclosures with Your Permission

We will not use or disclose medical information about you for any other purposes unless you give us your written authorization to do so. If you give us written authorization to use or disclose medical information about you for a purpose that is not described in this notice, then, in most cases, you may revoke it in writing at any time. Your revocation will be effective for all medical information about you that we maintain, except for information we have already released based on your authorization.

Your Rights

You may make a written request to us to do one or more of the following concerning medical information about you:

- To put additional restrictions on our disclosure of medical information about you we do not have to agree to your request.
- To communicate with you in confidence about medical information about you by a different means or at a different location than we are currently doing you must do by a request in writing and must specify the alternative means or location.
- To see and get copies of medical information about you, we do not have to agree to your request.
- To amend medical information about you, in some cases we do not have to agree to your request.

Complaints

If you believe your privacy rights have been violated, you may complain to us in writing or to the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

Conclusion

PHI use and disclosure by us is regulated by a federal law known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize the Privacy Standards. The Privacy Standards will supersede any discrepancy between the information in the Notice and the Privacy Standards.

Client Signature Date

NEUROLOGIC THERAPY SPECIALISTS, LLC
dba TOUCHSTONE REHABILITATION

PHOTO AND VIDEOTAPE RELEASE FORM

I, the undersigned, hereby consent without further consideration or compensation, to give Neurologic Therapy Specialists, LLC; dba Touchstone Rehabilitation the absolute right and permission to use my photograph or video in its promotional materials and publicity efforts.

I hereby grant permission to Neurologic Therapy Specialists, LLC to crop, screen or alter the photograph or video as necessary for use on materials produced by and on behalf of Neurologic Therapy Specialists, LLC. I understand that these images may be used alone or in conjunction with other photographs, still or moving, sketches, advertising and publication in any manner an in any medium whatsoever without limitation or reservation.

I release all claims against Neurologic Therapy Specialists, LLC ; dba Touchstone Rehabilitation, their employees, agents and designees from liability for any violation of any personal or proprietary right I may have in connection with such use.

_____

Client name

_____

Client signature (I am 18 years of age or older)

_____

Guardian signature if under 18

Date:_____