Patient Registration Form

Patient Information

Patient Name		Gender	MALE	FEMALE
Street Address		City, State, Zip		
DOB		SS #		
Cell Phone Number		Secondary Phone Number		
Email Address				
Emergency Contact Name		Emergency Contact Phone		
Employer Name		Job Title		

Insurance Information

Primary Insurance			
Policy Holder		DOB	
Secondary Insurance			
Policy Holder		DOB	

Consent for Treatment

I, ______________________ hereby authorize GSC Therapy Services to provide therapy services

as prescribed by my physician and/or outlined in my plan of care by my therapist.

Signature: ______________________ Date: __________

If patient is a minor, consent for treatment must be signed by an adult.

Name: ______________________ Relationship to patient: __________

I hereby authorize GSC Therapy Services to release any information acquired in the course of my examination or treatment to referring physician or insurance carrier. I hereby authorize all physicians in my healthcare to release my medical records to GSC Therapy Services in order to carry out my treatment, payment, and healthcare operations.

Signature: ______________________ Date: __________

The financial policy of GSC Therapy Services has been explained to me and I acknowledge full responsibility for all charges incurred, regardless of possible insurance coverage. I hereby authoirze GSC Therapy Services to obtain, on my behalf, any insurance information covered by "The Privacy Act" from my insurance company(s) files. I hereby authoirze payment directly to GSC Therapy Services for medical services and I further agree to pay all collection costs and attorney fees that may be incurred to enforce collection of any amounts outstanding.

I understand that GSC will bill my primary insurance as a courtesy to its patients, but it is important I understand and verify my own benefits.

I understand that with the exception of Medicare, GSC will not bill any secondary insurances and that I am responsible for any charges that my insurance may not cover.

Signature: ______________________ Date: __________

To our patients. This notice describes how health information about you (as a patient of this Practice) may be used and disclosed and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability And Accountability Act of 1996 (*HIPAA*) Our practice is dedicated to maintaining the privacy of your health information. We are required by Law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

Notice of Privacy Practices

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use of disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent threat.
5. If you are a member of U.S or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement offic
8. For Worker's Compensation and similar programs.

Your rights regarding your health information

1. Communications: You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the office manager at the contact information listed below.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete. And as long as the information is kept for our practice. To request an amendment your request must be made in writing and submitted to the office manager at the contact information listed below. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated. You may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the office manager for handling complaints. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

Contact Information: Clinic Manager
GSC Therapy Services
4902 S Val Vista Drive, Suite B102
Gilbert, AZ 85298

Signature

I hereby acknowledge that I have been presented with a copy of GSC Therapy Services Notice of Privacy Practices.

Name of Patient : ____________________

Signature: ____________________ Date: ____________________