

vital REHABILITATION

PATIENT REGISTRATION FORM

(KARTA REJESTRACYJNA PACJENTA/FORMULARIO DE REGISTRO DE PACIENTES)

PATIENT INFORMATION

(Informacja O Pacjencie/Nombre Del Paciente)

Last Name (Nazwisko/Apellido):		First Name (Imie/Nombre):		Guardian's Name (Nazwisko Opiekuna/Nombre del tutor):		Sex (Plec/Sexo): <input type="checkbox"/> M <input type="checkbox"/> F	
Address (Adres/Dirección):				City, State, Zip Code (Miasto, Stan, Kod Pocztowy/Cuidad, Estado, Código postal):			
Home Phone (Numer Telefonu/Telefono):				Social Security No.(Numer Social Security/ número de seguro social):			
Work Phone				Date of Birth (Data Urodzenia/Fecha de Nacimiento):		Age: <input type="checkbox"/> 0-17 yrs. <input type="checkbox"/> 18 yrs.- older	
Cell Phone				Height (Wzrost/Altura):		Weight (Waga/Peso):	
Reason for Visit (Powod Wizyty/Motiva de visita):							
Referring Physician (Lekarz Referujacy/Refiriéndose Médico):				Physician's Phone No. (Telefon Lekarz/Medico telefono):			
Employer (Miejsce Zatrudnienia/Empresario):				Occupation (Zawod/Ocupacion):			
How Did You Hear About Vital? Skąd dowiedziałeś się o Vital? Como se entero de Vital?		<input type="checkbox"/> Doctor <input type="checkbox"/> Insurance <input type="checkbox"/> Attorney		<input type="checkbox"/> Polish Yellow Pages <input type="checkbox"/> Yellow Pages <input type="checkbox"/> In Neighborhood		<input type="checkbox"/> Walked-by <input type="checkbox"/> Friend/Other _____	

INSURANCE INFORMATION

(Ubezpieczenia Informacje/Información del Seguro)

PRIMARY INSURANCE NAME (Głowne Ubezpieczenia/ Primaria de Seguros):				SECONDARY INSURANCE NAME (Ubezpieczenia Uzupetniajace/Seguro Secundario):			
<input type="checkbox"/> Worker's Comp. Injury Date _____		<input type="checkbox"/> Commercial/PPO _____		<input type="checkbox"/> Commercial/PPO _____		<input type="checkbox"/> Other _____	
<input type="checkbox"/> Commercial/PPO _____		<input type="checkbox"/> Cars Ins. _____					
<input type="checkbox"/> Other _____							
Telephone No. (Telefon/Telefono):				Telephone No. (Telefon/Telefono):			
Group No. (Numer Grupy/ Número de grupo):				Group No. (Numer Grupy/ Número de grupo):			
Policy No. (Numer Polisy/Número de Póliza):				Policy No. (Numer Polisy/Número de Póliza):			
Effective Date (Data wejścia w życie polisy/Fecha de vigencia):				Effective Date (Data wejścia w życie polisy/Fecha de vigencia):			
Policy Holder's Name (Ubezpieczający nazwisko /Nombre del titular de la política):				Policy Holder's Name (Ubezpieczający nazwisko /Nombre del titular de la política):			
Relationship to Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child							

IN CASE OF EMERGENCY, CONTACT

(Alarmowe/Contacto de Emergencia)

Relative/Friend/Guardian:	Phone No.:
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OFFICE USE ONLY:

<input type="checkbox"/> RETURNING PATIENT; NO CHANGES TO INFO	<input type="checkbox"/> Adult <input type="checkbox"/> Pediatric	Service: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> Other _____
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 Other _____

REFERRAL TAKEN BY:

DATE:

Eval. Scheduled For:

ILLNESSES/CHOROBY/ENFERMEDAD

(Check if you have any of the following/Proszę zaznaczyć przebyte choroby i/lub stany przewlekłe)

Alcoholism/Alkoholizm/Alcoholismo	Eye problems/Choroby oczu/problemas oculares	Pacemaker/Rozrusznik serca/ marcapasos
Anemia/Anemia/Anemia	Fractures/Zlamania/ Fracturas	Phlebitis/Zapalenie zyl/ flebitis
Arthritis/Artretyzm/Artritis	Glaucoma/Jaskra	Rheumatic fever/ Goraczka reumatyczna/ la fiebre reumática
Bleeds easily/Latwe krwawienia/Sangra con facilidad	Heart disease/Choroby serca/Enfermedades del Corazón	Rubella, German Measles/Rozyczka/ la rubéola, el sarampión alemán
Blood transfusion/Transfuzja krwi/La transfusión de sangre	Hepatitis/Zapalenie watroby	Sport contusions/Kontuzje sportowe/ contusiones en el deporte
Brain injury/Uraz mozgu/lesión cerebral	High Blood Pressure/Wysokie cisnienie krwi/Presión arterial alta	STDs/ Choroby weneryczne/ enfermedades de transmisión sexual
Cancer, tumor/ Rak, nowotwor	Implants/Implanty (sruby, blaszki, druty, czesci plastikowe, itp.)/Implantes	Stomach ulcers/Wrzody zoladka lub dwunastnicy/ úlceras de estómago
Depression/Depresja/Depresión	Liver disease, jaundice/Choroby watroby, zoltaczka/Enfermedades del Hígado	Stroke/Udar mozgu/Golpe
Diabetes/Cukrzyca	Lung disease/Choroby pluc/Enfermedades Respiratorias	Suicide attempts/Proby samobojcze/ intentos de suicidio
Drug abuse/Uzywanie narkotykow/uso indebido de drogas	Mumps, measles, chicken pox/Swinka, odra, ospa wietrzna/ Paperas, sarampión, varicela	Thyroid disease/Choroby tarczycy/ la enfermedad de la tiroides
Eczema, hives, rashes/Egzema I inne choroby skorne/eczema, erupción cutánea, urticaria	Nervous breakdown/Zalamanie nerwowe/ ataque de nervios	Other/Inne choroby
Epilepsy, seizures/Padaczka/epilepsia, convulsions	Osteoporosis/Osteoporoza	

ALLERGIES/ALERGIE, UCZULENIA/ALERGIAS

Cortisone, hydrocortisone	Medications/leki	Other/Inne
Food/Alergie pokarmowe	Ointments, creams/ Masci, kremy	
Lidocaine/Lidokaina	Seasonal / Uczulenia sezonowe (np. katar sienny)	

LOSS OF SENSATION/UTRATA CZUCIA SKORNEGO/PERDIDA DE LA SENSIBILIDAD

Numbness/Zdretwieua	Touch (if yes, indicate area/Dotykn (proszę wskazać miejsce)	Sharp/Ostre klucie
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Warm-cold/Ciepło-zimno

Other/Inne

HOSPITALIZATION, SURGERY / HOSPITALIZACJE, OPERACJE/HOSPITALIZACION, CIRUGIA

List illnesses or surgeries and its approx.date. Include normal pregnancies.

Proszę wymienić wszystkie przebyte choroby / operacje wymagające pobytu w szpitalu (także ciąży)/ Lista de enfermedades o cirugías y sus approx.date. Se incluyen los embarazos normales.

Date (Year)/Data (Rok):

MEDICINES / STOSOWANE LEKI/MEDICAMENTOS

List medicines, birth control pills, vitamins or herbs you take with or without prescription.

Proszę wymienić leki, pigułki antykoncepcyjne, witaminy oraz zioła, zazywane na recepte lub bez

Lista de medicamentos, píldoras anticonceptivas, vitaminas o hierbas que usted toma con o sin receta médica

Have you ever had previous treatment such as orthopedic, chiropractic or physical/occupational/speech therapy? Please underline correct.

Czy kiedykolwiek korzystał (a) Pan(i) z pomocy ortopedy, chiropraktyka, fizjoterapii, terapii zajęciowej lub terapii mowy?

Proszę podkreślić właściwa.

¿Ha tenido tratamiento previo, tales como ortopedia, quiropráctica o física / terapia de lenguaje ocupacional /?

Subrayar correcta.

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Financial Policy, Release of Information, Assignment of Benefits

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to us. If your insurance company does not pay us within a reasonable time period, we require you to pay the outstanding balance.
- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the copayment at the time of service.
- If you have a co-pay, you may either pay each time you come for your appointment or you may pay in advance to cover all visits for the week. Once the insurance company has begun to process our bills, if there is a balance due, we will send you a statement each month for the amount you owe – i.e. deductible, coinsurance, co-pay, until all claims have been processed. **Payment is due upon receipt of our bill.**
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis.
- Unless other arrangements have been made in advance by you, your health insurance carrier, also agree upon by Vital Rehabilitation, **payment for services are due at the time of service.**
- In the event your health plan determines a service to be “not covered” and we are unaware or you do not have authorization, you will be responsible for the complete charge.
- You must inform our office of all insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges that are denied.
- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian for payment.

Payments and Patient Signature

- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees, and court fees shall become your responsibility in addition to the balance due this office.
- A **\$25.00 fee** will be charged for all **“No Shows” & Cancellations without 24-hour advance notice**. This fee is not reimbursable by insurance.
- I have read and understand the financial policy of Vital Rehabilitation and I agree to be bound by its terms. I also understand that such terms may be amended from time to time by this office.
- I authorize the release of information necessary for treatment, payment & health care operations. I also authorize assignment of benefits for services rendered by Vital Rehabilitation.

I do hereby consent to such treatment by the authorized personnel of Vital Rehabilitation as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment except for act of negligence.

I have read and understand the above information. I believe the information I have given to be accurate/true.

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Patient or Parent/Guardian Signature

Date

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 READ IT CAREFULLY.

If you have any questions about this Notice please contact: our Privacy Officer: Richard Green, M.S.

Vital Rehabilitation in accordance with the federal Privacy Rule, 45 CFR parts 160 and 164 (the "Privacy Rule") and applicable state law, is committed to maintaining the privacy of your protected health information ("PHI"). This Notice of Privacy Practice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by accessing our website (vitalrehabilitation.com), calling the office and requesting for a revised copy or asking for one at the time of your next appointment.

1. HOW THE PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

A. Uses and Disclosures of Protected Health Information without Authorization Needed

Your protected health information may be used and disclosed by your physical therapist, our office's staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice. Following are examples of the types of uses and disclosures of your protected health information that the physical therapist's office is permitted to make without written authorization. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose your protected health information to other physicians, physician assistants, nurse practitioners, and physical therapists who may be treating you when we have the necessary permission from you to disclose your protected health information. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician, physical therapist or health care provider who, at the request of your physical therapist, becomes involved in your care by providing assistance with your health care, physical therapy diagnosis or treatment to your physical therapist.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a physical therapy visit may require that your relevant protected health information be disclosed to the health plan to obtain approval for the therapy.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physical therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of physical therapy students, licensing, marketing and fundraising activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your physical therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

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We will share your protected health information with third party “business associates” that perform various activities (e.g., medical equipment ordering) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other clinic marketing activities. For example, your name and address may be used to send you a newsletter about our practice and services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you. **We will not disclose your information to any outside entity that would engage in any marketing, telemarketing or sales.**

B. Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physical therapist or the physical therapist’s practice had taken an action in reliance on the use or disclosure indicated in the authorization.

C. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. **(Request HIPAA FORM 005)** If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physical therapist may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: Emergencies rarely happen in a physical therapy clinic. If one does, we may use or disclose your protected health information to provide, or allow emergency medical personnel to provide, emergency treatment. If this happens, your physical therapist shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your physical therapist, emergency medical personnel or physician is required by law to treat you and they have attempted to obtain your consent but are unable to obtain your consent, they may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your physical therapist or another physical therapist in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physical therapist determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

D. Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government

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agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal laws and Idaho state codes.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biological deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: Not applicable to physical therapy clinics

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veteran Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President and others legally authorized.

Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or receives your protected health information in the course of caring for you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et seq.

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2. Patient's Rights. Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

A. You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your physician and the practice uses for making decisions about you.

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have any questions about access to your medical record. Request **HIPAA FORM 002** if you need a copy of your records

B. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operation. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physical therapist is not required to agree to a restriction that you may request. If physical therapist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your physical therapist does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physical therapist. You may request a restriction by filling out the appropriate Restriction of Protected Health Care Information form. Request **HIPAA FORM 005**.

C. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in our Privacy Officer. Request **HIPAA FORM 014**.

D. You may have the right to have your physical therapist amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer to determine if you have questions about amending your medical record. Request **HIPAA FORM 006**

E. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have to you, for a facility directory, to family members or friends involved in your case, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations. Request **HIPAA FORM 011**.

F. You have the right to obtain a paper copy of this notice from us, upon request, from our office at any time.

3. Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. You may contact our Privacy Officer, Richard Green, MS at (773) 685-8482 or rgreen@vitalrehabilitation.com for further information about the complaint process.

I have read and acknowledge Vital Rehabilitation's compliance with HIPAA.

Patient Name _____

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Signature _____ Date _____