



Spine Orthopedic & Sports Physical Therapy



To protect your identity and due to the Federal Health Insurance Portability and Accountability Act (HIPAA, Patient Privacy Act) these forms should be filled out in their entirety.

Thank You,

SOS Physical Therapy



Spine Orthopedic & Sports Physical Therapy

Please fill-out entire form completely and legibly



Dear Patient,

We realize that you have several physical therapy clinics to choose from, and we appreciate being given the chance to serve you. Below are some office guidelines for you to remember.

Aquatic Therapy

- For your safety, water shoes must be worn at all times while in the pool area.
- Lockers are provided for you to use while you are here, please do not leave your belongings overnight.
- We appreciate you helping us keep our pool clean by showering first to remove all body lotions, perfumes, deodorants, etc.
- Please bring your own towels.
- Children and visitors are not allowed in pool area.

We do not have the facilities to supervise your small children, and encourage you to come without them. If you **MUST** bring your children, for their own safety, they are not allowed to play on or near any equipment. You are responsible for any damages caused by your children.

Please turn your cell phone off while in the treatment area.

Insurance Information

- The information we relay to you regarding your insurance is only a quote of what your insurance company told us when we called to verify your benefits. How the claim is processed on their end may be different from what we were told.
- Some insurance companies and all workmen's compensation companies require **PRE-AUTHORIZATION** for treatment. You can help by calling your referring physician's office or insurance company and encouraging them to initiate/process the paperwork.
- We have no input on the authorization process other than sending the required forms.
- Medicare has a set limit on physical therapy benefits. In addition you need a new referral from your referring physician every 30 days even though you did not use last month's visits.
- Payment is required when services are rendered. This allows us to offer quality medical care while keeping costs under control. You may pay by cash, Visa, MasterCard, American Express or personal checks with proper identification. A \$35.00 fee will be charged for returned checks. We do not accept post-dated checks.
- We participate with a number of health plans. If we participate with your health plan, we will file a claim with your carrier. It is important that you are financially responsible for non-covered services. Insurance co-payments are required at the time of service, if not your insurance plan could be in jeopardy.
- It is your responsibility to provide us with correct insurance billing information at the time of visit and to make changes to the information when necessary. If correct insurance information is not given and/or payments are denied by the insurance company, for any reason, you are responsible for payment in full. Refusal to comply will result in referral to an outside collection agency.
- We try to see our own patients whenever possible; however, on certain occasions when we are not available, we do have cross coverage. We trust that you will understand and assist us in giving you the best care during these cross coverage periods.

I have read the agreement and fully understand its contents.

Signature: _____ Date: _____



Spine Orthopedic & Sports Physical Therapy
Please fill-out entire form completely and legibly
Patient Registration Form

Patient Information: PHYSICAL THERAPY METABOLIC PROGRAM OCCUPATIONAL THERAPY

Date: ____/____/____
MALE FEMALE

LAST NAME FIRST NAME AGE

STREET ADDRESS CITY STATE ZIPCODE

HOME PHONE # CELL # EMAIL ADDRESS (REQUIRED IN ORDER TO RECEIVE APPT. REMINDERS)

OCCUPATION EMPLOYER PHONE #

EMERGENCY CONTACT PHONE # if Patient is a MINOR Parent/Guardian Name and Signature Here

SOCIAL SECURITY # _____ DOB: ____/____/____ SINGLE MARRIED DIVORCED WIDOWED

WORK STATUS: CURRENTLY EMPLOYED RETIRED DISABLED

My Condition Information:

**** All Information is required ****

My injury/aliment is related to...

AUTO/PERSONAL INJURY:

DATE OF INCIDENT: ____/____/____

WORK INJURY: *COMPLETE ALL INFORMATION BELOW*

DATE OF INJURY: ____/____/____

YOUR COMPANY HR NAME: _____

INSURANCE ADJUSTER NAME: _____

INSURANCE ADJUSTER PH#: _____

NO INJURY: WHAT DO YOU THINK MAY HAVE CAUSED IT?

I have already had...

SURGERY: *WHEN AND WHAT TYPE?*

PHYSICAL THERAPY: *WHEN AND WHERE?*

HOME HEALTH CARE: *ARE YOU STILL RECEIVING IT?*

Payment Info:

I am paying TODAY by ...

INSURANCE

WORKERS COMP: *MUST HAVE ALL INFORMATION PROVIDED UNDER " MY CONDITION..."*

SELF-PAY (CASH, CHECK, CREDIT)

I HAVE AN ATTORNEY

Referral Info:

How did you hear about us?

Referring Doctor:

Phone # _____

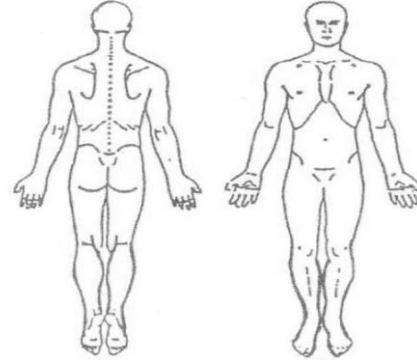


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 Please fill-out entire form completely and legibly
Patient Medical History

Name: _____

Date: _____

Using the drawing, please mark the areas where you feel the pain.



Please circle all that apply to you:
 explanation and an approximate date:

If "Yes" please give a brief

- | | |
|------------------------|--------------|
| Allergies | Yes _____ |
| No _____ | |
| Asthma | Yes _____ |
| No _____ | |
| Bowel/Bladder Problems | Yes No _____ |
| Bronchitis/Emphysema | Yes No _____ |
| Cancer | Yes No _____ |
| Diabetes | Yes No _____ |
| Headaches | Yes No _____ |
| Heart Attack | Yes No _____ |
| Heart Disease | Yes No _____ |
| Hernia | Yes No _____ |
| High Blood Pressure | Yes No _____ |
| Kidney Problems | Yes No _____ |
| Metal Implants | Yes No _____ |
| Nervous Disorders | Yes No _____ |
| Osteoporosis | Yes No _____ |
| Pacemaker | Yes No _____ |
| Previous Surgery | Yes No _____ |
| Seizures | Yes No _____ |
| Sensitivity to Cold | Yes No _____ |
| Sensitivity to Heat | Yes No _____ |
| Stroke or TIA | Yes No _____ |
| Do you Smoke? | Yes No _____ |

Pain rating at rest: no pain 1 2 3 4 5 6 7 8 9 10 (circle one)

Pain rating at rest: no pain 1 2 3 4 5 6 7 8 9 10 (circle one)

Please list any anti-inflammatory, muscle relaxers, or pain medications that you are currently taking:

What are your goals for physical therapy? _____



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Financial Agreement

I understand and agree that I am totally responsible and liable for payment of all the charges assessed for professional services rendered and will pay any sum due upon demand. I understand that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am primarily responsible for all charges regardless of my existing medical coverage. In the event that my insurance forwards payment directly to me, instead of Spine, Orthopedic and Sports Physical Therapy, I will immediately deliver such payment directly to Spine, Orthopedic and Sports Physical Therapy. I understand and agree that if it becomes necessary to commence legal action for the collection of any outstanding charges on my account, I will be responsible for any costs and or court fees, in addition to the outstanding balance. Once the insurance company pays, I understand there is a 1.5% late charge on any balance 30 days or over. **Initials:**_____

I hereby give authorization for payment of insurance benefits to be made directly to Spine, Orthopedic and Sports Physical Therapy for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement is as valid as the original. **Initials:**_____

Co-Payment/Insurance Policy

Some insurance policies require a co-payment for each visit. We are under contractual obligation to collect these co-pays. It is your responsibility to make these co-payments. You are also responsible for any and all supplies, such as braces and exercise equipment, which are provided to you and are not covered by your particular plan. Insurance benefits and plans change often. Spine, Orthopedic and Sports Physical Therapy has no input or controls over what your benefits are. Deductibles usually start over every January. We will assist as much as possible, but we encourage you to contact your plan representatives and verify your benefits, co-payments, etc. Keep all correspondences from your insurance plan relating to the treatments.

I am financially responsible for insurance deductibles, co-insurance, co-payments, and supplies that are not covered by insurance. **Initials:**_____

Appointment Policy

I understand that my doctor has prescribed physical therapy for me and that physical therapy is an ongoing process and requires regular attendance to be optimally effective. **Initials:**_____

Appointments

Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival of greater time than 15 minutes may result in a shortened treatment or cancellation. We require advance notice of 24 hours for cancellation. Failure to show for an appointment or a cancellation without sufficient notice may be subject to a \$75.00 charge. **Initials:**_____

Authorization for Treatment

I hereby consent to authorize all therapy treatments, which in conjunction with the judgments of the attending physician, may be considered necessary or advisable for the diagnosis or treatment of the above named patient at Spine, Orthopedic and Sports Physical Therapy. **Initials:**_____

Date: _____

Signature (Parent or Guardian if Patient is a minor)

Patient Name: _____



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HIPAA Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Spine, Orthopedic and Sports Physical Therapy will follow the terms of this notice. Please review it carefully, and then sign at the bottom. If you want a copy for your records, please ask.

Our pledge regarding health information

We understand that health information about you and your healthcare is personal. We are committed to protecting health information about you. We create a record of the care and services that you receive from us. We need this record to provide you with the quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal physical therapist or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that are currently in effect.

Confidentiality during treatment

The majority of treatment is done in a private treatment room. Certain procedures may take place in the gym area. Every effort will be made to protect your privacy as much as possible, but conversations may be overheard in the gym. You have the right to confidentiality, and if you feel that this is not adequate you should inform the treating therapist. We ask you to respect what you may overhear from someone else.

If you bring someone with you into a treatment room, you are giving us your implied consent to discuss your treatment in front of your visitor.

How we may use and disclose health information about you

For treatment

We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to the therapists and staff working in our office, as well as to your referring physician and his/her staff, or the covering physician.

For payment

We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about your office visit so that your health plan will pay us or reimburse you for the visit. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

As required by law

We will disclose health information about you when required to do so by federal, state, or local law.

Right to Request Restrictions

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. To request a restriction, you must make your request in writing to the Office Manager. In your request, you must tell us what information you want to limit and to whom you want the limits to apply, for example, use of any information by a specified nurse, or disclosure of a specified surgery to your spouse.

Acknowledgement of Receipt of this Notice

I hereby acknowledge that I have read and understand the above information.

Signature: _____ **Date:** _____



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Dear Patient,

This office participates in many of the different health care programs. Each PPO, HMO, POS, EPO, or other Health Care Plan is different and can have many different sub-plans or groups. We may collect your co-payment here and submit the remainder of the bill to your health plan for reimbursement. We cannot tell from your health care what is covered by your particular plan, the benefits we are quoted are only an estimate and not a guarantee of payment. You, as the insured person, are responsible for knowing about your policy and its coverage so be advised that any portion of your treatment that is not covered by your insurance company you, the patient, will be liable. Also attention all Medicare patients, please be aware that per Medicare guideline \$1900 is the maximum for the patient per the calendar year.

Your therapist may recommend a procedure because they feel it is necessary to your recovery, without their knowledge of what your insurance or health care plan covers. If there is a problem, you should notify the therapist at that time so arrangements can be made.

Any portion of your bill identified by your insurance plan as being your responsibility to pay will be billed to you for payment; it is your responsibility to follow up with your insurance company if you have any questions regarding their payment or lack thereof. If you have any further questions please contact your insurance company.

Thank you,
Spine Orthopedic & Sports Physical Therapy

I, _____ have read and understand the following statement and have received a copy of this form on, date: _____.



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Assignment of My Benefits

Please fill out to the best of your knowledge

Benefit Information:

What is your deductible amount? \$ _____ and Coinsurance % _____

Are there any maximums?

Policy Information:

Patient Name: _____ ID: _____ DOB: __/__/__

Insurance Policy 1 Name/Number/Group # _____

***Is the patient insured through some else's policy? (Give their information below)*

• Policyholder Name: _____ DOB: __/__/__ SSN: _____

• ADDRESS (if different than patient) _____

• Relationship to Patient: ___ Spouse ___ Parent ___ Other

• Employer _____ Phone # _____ Claim # _____

Insurance Policy 2 Name/Number/Group# _____