Physical Therapy

# PATIENT INFORMATION FORM

Date____/____/____ Social Security ____-____-____ DOB____/____/____

Last Name_____ First_____ MI_____

Address_____ City_____ ST_____ Zip_____

Telephone #: (HM) _____ (WK) _____ (CELL) _____

E-mail Address:_____

Martial Status ( )M ( )D ( )S ( )W

Occupation _____ Employer _____

Address_____ City_____ ST_____ Zip_____

## RESPONSIBLE PARTY

Person Responsible _____ Relationship to Patient_____

Social Security _____ DOB ____/____/____

Mailing Address_____ City_____ ST_____ Zip_____

Telephone No.: (HM) _____ (WK) _____ (CELL) _____

Occupation_____ Employer _____

Employers Address_____ City_____ ST_____ Zip_____

## INSURANCE INFORMATION

Policy Holders Name _____ Relationship to Patient _____

Policy Holders Date of Birth ____/____/____ Policy Holders SSN ____/____/____

Insurance Carrier Name _____ Phone _____

Policy ID # _____ Group # _____

Claims Mailing Address _____

City_____ ST_____ Zip _____

## EMERGENCY INFORMATION

Contact Person_____ Relationship_____

Address _____ City_____ St_____ Zip_____

Telephone No.: (HM) _____ (WK) _____ (CELL) _____

# Patient Medical History

Name: _____ Injury Date: _____ Referring Doctor: _____

Body part(s) injured: _____

Briefly describe how the injury / accident occurred: _____

_____

Date of initial doctor visit after injury: _____ # of Surgeries for this injury: 0 1 2 3+

Other surgeries and dates: _____

Prescription medication currently taking: _____

Allergies to medications: _____

Are you currently receiving Home Health Care ( ) yes ( ) no

Do You currently have an attorney ( ) yes ( ) no

If yes, name of attorney _____

Have you had any Physical or Occupational Therapy this year ( ) yes ( ) no .....

If yes, when and where _____

Which of the following doctors or treatment providers have you seen regarding this injury?

| | Yes | No |
|---|---|---|
| General practitioner | | |
| Orthopedist | | |
| Neurologist | | |
| Physical Therapist | | |
| Chiropractor | | |
| Acupuncturist | | |
| Massage Therapist | | |

| Diagnostic Tests: | Yes | No |
|---|---|---|
| MRI | | |
| X Ray | | |
| CT Scan | | |
| Other: _____ | | |

Please let us know of your significant medical history for appropriate care:

| | Yes | No |
|---|---|---|
| Cancer | | |
| Pacemaker | | |
| Pregnant | | |
| Seizures | | |
| Pins / metal implants | | |
| Diabetes | | |
| Circulation disorder | | |
| Blood disorder | | |
| Arthritis | | |
| High Blood Pressure | | |
| Stomach / Ulcers | | |
| Infection problems | | |
| Head injury | | |
| Multiple Sclerosis | | |
| Parkinson's disease | | |
| Stroke / TIA | | |
| Kidney disorder | | |
| Heart disorder | | |
| Fractures | | |
| Frequent headaches | | |

| | Yes | No |
|---|---|---|
| Numbness or tingling | | |
| Weakness | | |
| Loss of balance | | |
| Lung disorder | | |
| Liver disorder | | |
| Osteoporosis | | |
| Tuberculosis | | |
| Hepatitis | | |
| Vision disorder | | |
| Hearing disorder | | |
| Psych disorder | | |
| Weight loss or gain | | |
| Sleeping disorder | | |
| Pain at night | | |
| Hernia | | |
| Varicose Veins | | |
| Joint Replacement | | |
| Bladder disorder | | |
| Smoker | | |

Pertinent information that will assist us with you therapy treatment: _____

_____

Goals/expectations while attending physical therapy: _____

_____

## PAIN SCALE

(CIRCLE THE NUMBER OF YOUR PAIN AT ITS WORST)

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst Pain Possible

Rapides

Physical Therapy

# CANCELLATION / NO-SHOW POLICY

To achieve the best outcome, we and / or your doctor have recommended a treatment plan to optimize your results. To attain these results, it is important that you attend your therapy sessions as scheduled.

We will give you 100% effort to restore your health, but we need 100% from you as well. We reserve time in our schedule specifically for you. We ask that you make every effort to keep scheduled appointments.

Please review the guidelines we have in place. We realize that emergencies and scheduling conflicts happen. However, we need your help to optimize our efficiency in the clinic and to allow proper accommodation to other patients.

- In the event of cancellation, notify us at least 24 hours in advance. If you are unable to give 24-hour notice, you may be subject to a $25.00 charge for a cancellation without 24-hour notice. This charge will not be covered by insurance, and will have to be paid out of pocket.

- Workers' Compensation and Personal injury patients - all cancellations and missed visits are forwarded to your case manager and doctor. Your worker's compensation benefits can be cancelled or reduced if you miss your treatment sessions without excuse. Treat this like your job. You are responsible to show up to your treatment sessions just like the responsibility to showing up for your job. There are medical legal aspects and you have responsibility to follow through your medical care to restore your health so that you can perform your job duties at full strength. Therefore, do not miss visits, and make up all visits if you must reschedule.

- If you are going to be more than 15 minutes late, please notify us, so that we may accommodate for you.

DO NOT CANCEL if you are feeling worse and believe the treatment is not working. Keep your appointment and discuss any changes with your therapist. Understand that your pain will often fluctuate throughout your treatment.

DO NOT CANCEL if you are feeling better. Keep your appointment and follow treatment plan for follow through. Your plan is modified and progressed as the treatment plan progresses to optimize your health.

Thank you for providing our office and other patients with this courtesy. Please sign below so that you understand and agree to the terms of this policy.

_____Signature of Patient

We are happy that you have chosen Rapides Physical Therapy for your rehabilitation and recovery to good health. Thank you for your consideration of and follow through for your health, our staff and other patients.

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Co-pay's and deductibles: In this day and age, we understand that health insurance costs have changed throughout the years and some of the up front burden has shifted to you and sometimes it is not as easy to handle the cost up front. We want to help you get the treatment that you need.

Copays are a partial re-imbursement to us for your physical/occupational therapy sessions. Copays are contractual obligations between you, your insurance company and us. They are a partial payment for your services and the insurance company pays all or some of the rest of the cost.

Your insurance requires a _____co-pay for each visit.

If this amount is difficult each visit, you may pay_____ each visit and we will bill you at the end with any amount due once your insurance pays their responsibility.

We will work with you so that you are able to get the physical/occupational therapy services that you need.

In the event that Rapides Physical Therapy must retain a collection agency or law firm to collect past due balances owed to Rapides Physical Therapy, you agree to pay any and all collection agency fees, court cost, attorney fees or incidental costs associated with collecting.

Patient Name:_____

Patient Signature:_____

Date:_____

# Rapides Physical Therapy Payment Policies

## To the Insured and Un-Insured patient:

Your insurance is a contract between you, the insurance company, and employer. We are not a party to that contract. Payment for services is due at the time of service. We accept cash, check, debit and credit cards. If you request, we will deal directly with your insurance company for the reimbursement.

Our fees are generally considered to fall within the acceptable range by most companies, and therefore covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage such as 80% of "UCR." UCR is defined as usual, customary, and reasonable. This statement does not apply to companies that reimburse based on arbitrary "schedule" of fees which bears no relationship to the current standard and cost of care in this area. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

## Assignment of Benefits

- ☐ I will pay at the time of service and receive a 30% savings.
- ☐ I would like to have you deal directly with my insurance company.
- ☐ I would like to set-up a payment plan arrangement.
- ☐ I am presently seeking legal counsel (third party payer) and would like for you to deal directly with my attorney regarding payment.

I hereby instruct and direct _____ insurance company/worker's comp/ third party payer to pay by check made out and mailed to:

Rapides Physical Therapy
3016 Jackson St. Alexandria, LA 71301

If my/this current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it to the above address for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

*Signed* _____ *Date* _____

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

- ☐ A photocopy of this Assignment shall be considered as effective and valid as the original.
- ☐ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- ☐ I authorize the use of this signature on all insurance submissions.
- ☐ I authorize Rapides Physical Therapy to deposit checks made in my name.
- ☐ I authorize Rapides Physical Therapy to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- ☐ I understand that I am financially responsible for all charges whether or not paid by insurance.

*Signed* _____ *Date* _____

*Witness* _____

# RAPIDES PHYSICAL THERAPY
# 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 REVIEW IT CAREFULLY.

Rapides Physical Therapy is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

## Disclosure of Your Health Care Information

### Treatment.
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

> *"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Rapides Physical Therapy."*
>
> *"It is our policy to provide a substitute health care provider, authorized by Rapides Physical Therapy to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

### Payment.
We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

> *"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Rapides Physical Therapy for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

### Workers' Compensation.
We may disclose your health information as necessary to comply with State Workers' Compensation Laws. You the patient will be held accountable for attendance of all scheduled appointments for the injury sustained. All appointments and documentation will be reported directly to the Worker's Comp carrier/provider. The Worker's Compensation carrier/provider has the right to deny any or all treatments due to non-compliance.

### Emergencies.
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

### Public Health.
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

### Judicial and Administrative Proceedings.
We may disclose your health information in the course of any administrative or judicial proceeding.

### Law Enforcement.
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

### Deceased Persons.
We may disclose your health information to coroners or medical examiners.

### Organ Donation.
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

### Research.
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

### Public Safety.
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

### Specialized Government Agencies.
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing.
We may contact you for marketing purposes or fundraising purposes, as described below: (example)

*"As a courtesy to our patients; it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."*

Change of Ownership.
In the event that Rapides Physical Therapy is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Rapides Physical Therapy is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Rapides Physical Therapy amend your protected health information. Please be advised, however, that Rapides Physical Therapy is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Rapides Physical Therapy.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
Rapides Physical Therapy reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Rapides Physical Therapy is required by law to comply with this Notice.

Rapides Physical Therapy is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Rapides Physical Therapy by calling this office at 318-445-4455. If no one is available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints
Complaints about your Privacy rights or how Rapides Physical Therapy has handled your health information should be directed to the office manager by calling this office at 318-445-4455 if the office manager is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of _____/_____/_____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Rapides Physical Therapy with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____
Patient's Name (print)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date