ELITE
PHYSICAL & SPORTS THERAPY
FUNCTIONAL REHABILITATION @ WANDERMERE

Patient Name: _____ Date of Birth: _____ Sex: M F
First Last Please Circle

Address: _____
Street City State Zip

Home Phone: _____ Work: _____ Cell: _____
We call to remind patients of appointments the afternoon prior. Please put a star near the best phone number to call or an X if you wish not to be called ahead of time.

Driver's License #: _____ Social Security: _____

How did you hear of us? _____ E-mail address: _____

Employer: _____ Phone: _____
Name Address City, State Zip

If Work Related: Date of injury: _____ Claim #: _____ Doctor: _____

Company Ins: _____ Phone: _____

Employer at time of injury: _____

Emergency Contact Name: _____ Phone: _____

Address: _____
Street City State Zip

Relationship: _____

Is your injury from an <u>insured accident</u>: Auto Home Other Date of Injury: _____
Please circle if relevant

Brief summary of incident: _____

Primary Insurance: _____ Phone: _____

Claims Address: _____
Street City State Zip

Claim or ID #: _____ Group ID: _____

If insurance policy is listed under someone other than yourself be sure to complete this section

*Insured's Name: _____ *Insured Date of Birth: _____

*SS # of insured: _____ *Insured's relation to patient: _____

Secondary Insurance: _____ Phone: _____

Claims Address: _____
Street City State Zip

*Insured's Name: _____ *Insured Date of Birth: _____

*SS # of insured: _____ *Insured's relation to patient: _____

Health History

1. What are you here for today? _____
2. How long have you had this problem? _____
3. What activities increase your symptoms? _____
4. Recent Surgery? *Please describe* _____
5. Are other healthcare providers treating you for this condition? *Please list:*

   _____
6. Are you currently taking any medications for this or any other problem? *Please list*

   _____
7. Have you had any test(s) done for your current condition?

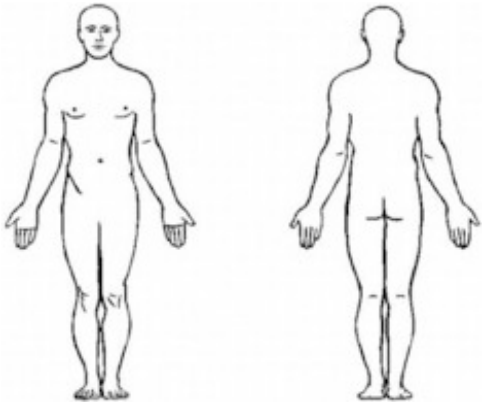
   __X-Ray __CT Scan __Electrical Nerve Tests
   __MRI __Bone Scan __Other

   Please list Results: _____
8. For how many minutes can you tolerate the following positions?

   Sitting_____Standing_____Walking_____Sleeping_____
9. Rate the physical demand of your work __Heavy __Moderate __Light __Sedentary
10. Are you currently working? ____Yes _____No
    a. If yes, what is your job title/duties? _____
    b. If no, is it due to your injury? ____Yes _____No

       When was your last day of work? _____
11. Describe your hobbies: _____
12. How is your general health? __Excellent __Good __Fair __Poor
13. What are your goals in coming to physical therapy today? _____

On the drawings, please indicate where you have symptoms:



CONSENT FOR CARE & TREATMENT **Elite Physical & Sports Therapy**

I the undersigned do hereby agree and give my consent for EPST to furnish medical care and treatment considered necessary and proper in diagnosing or treating his/her physical and medical condition.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to EPST. A photo copy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records to secure payment.

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. If you would like to know your PT benefit please inquire on your second visit and any information obtained from your insurance will be shared. We cannot guarantee the accuracy of information obtained from your insurance it is used as a reference. **Ultimately you are responsible for your bill, knowing and understanding your insurance benefits. At any time you can obtain your benefit information direct from your insurance company.** We require that arrangements for payment of your estimated share be made. If your insurance carrier does request a refund of payment made, you will be responsible for the amount of money refunded to your insurance company.

If payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to EPST. When you pay by check if your check is dishonored or returned for any reason, you expressly authorize EPST to add a NSF fee of $25.00 to your account for check processing.

The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies, including court costs, collection agency fees, and attorney fees.

INFORMATION PRIVACY

EPST will use and disclose your health information to treat you and to receive payment for care we provide. A detailed NOTICE OF PRIVACY PRACTICES is included to help you better understand our policies in regards to your personal health information. The terms of the notice may change however a current notice will be posted in our facility. The undersigned acknowledges receipt of this information.

I UNDERSTAND MY RESPONSIBLITIES:

_____ DATE _____

Signature of Adult Patient or Legal Guardian

Dear Patients:

Our no-show/cancellation policy is as follows:

A cancel or no show is documented in the event that the patient cancels or no-shows **within 24hrs of their scheduled appointment** and does not re-schedule the appointment within the same week**. In the event of three (3) cancellations or two (2) no-shows, the patient will be charged a fee of $25.00.** The patient will additionally be charged for each cancellation/no show thereafter. After a repeated record of canceling/no showing has been established, patients will no longer be able to schedule appointments ahead of time; they may however, call the day of and schedule an appointment at that time. In some cases, patients will be discharged.

We truly value our patients' time just as we hope that you value ours. Having said that, whenever a patient does not appear for scheduled appointments, everyone is affected – you do not get the treatment that was needed and we lose a spot that another patient could have filled.

Please make every effort to provide at least 24 hours notice if you find you are unable to keep your appointment. We understand unexpected conflicts can occur and that your life is as busy as ours. We strive to work with you to fit your schedule.

Thank you in advance for your understanding and cooperation,

Mike Kistler, MSPT/Owner

NOTICE OF PRIVACY PRACTICES

PATIENT RIGHTS- HIPAA

Elite Physical & Sports Therapy assures that patients are treated according to their rights defined by HIPAA.

1 **Complaints:** If you desire further information about your privacy rights, are concerned that we have violated your privacy rights, or disagree with a decision that we have made about access to Protected Health Information, you may contact Mike Kistler at 465-2139. You may also file written complaints with the Director, Office of Civil rights of the US Department of Health and Human Services. Upon request, Mike Kistler will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or with the Office of the Director.

2 **Right to Request Additional Restrictions:** You may request restrictions on our use and disclosure of Protected Health Information (1) for treatment, payment, and health care operations, (2) to individuals (such as a family member, other relative, close personal friend, or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction.

3 **Right to Receive Confidential Communication**s: You may request, and we will accommodate, any reasonable written request for you to receive Protected Health Information by alternative means of communication or at alternative locations.

4 **Right to Inspect and Copy Your Health Information:** You may request access to your medical record file, as well as your enrollment, payment, claims adjudication, case, medical management records, and your billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you request a copy or copies of your record you will be charged a cost-based fee of $.50 for each copy furnished directly to patient/legal guardian.

5 **Right to Amend Your Records:** You have the right to request that we amend Protected Health Information maintained in your medical record file, enrollment, payment, claims adjudication, case, medical management records, or billing records. We will comply with your request unless we believe that the information that would be amended is accurate and complete or other special circumstances apply.

6 **Right to Receive Paper Copy of This Notice:** Upon request, you may obtain a paper copy of the Notice, even if you agreed to receive such notice electronically.

_____ _____

Legal Guardian or Patient Signature Date

1/2013

Consent to treatment of a Minor Child

I authorize the staff at Elite Physical & Sports Therapy to administer physical therapy treatment to my child.

Childs Name: _____

Parent/Guardian's Signature: _____

Relationship: _____

Date: _____

Witness: _____