



Professional Therapy Services, LP
"Your Preferred Physical Therapy Provider"

Patient Information Sheet

Today's Date: _____ Diag/ICD-9: _____ Onset/DOI: _____

Patient Name: _____

Home Address: _____ City: _____ State: TX Zip: _____

Home Phone: () _____ Cell: () _____

Place of Employment: _____ Work Phone: _____

Employer Address: _____

Social Security #: _____ Sex: _____ Date of Birth: _____

Who is financially responsible for this bill? _____

Responsible Party Information

Name: _____ Relationship to Patient _____

Home Address: _____ City: _____ State: TX Zip: _____

Home Phone: _____ Cell: _____

Place of Employment: _____ Work Phone: _____

Social Security #: _____ Sex: _____ Date of Birth: _____

Nearest relative not living with you: _____ Home Phone: _____

Who may we contact in case of an emergency: _____ Home Phone: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

I UNDERSTAND AND AGREE THAT, (REGARDLESS OF MY INSURANCE STATUS); I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED; AND THAT A 25% FEE WILL BE CHARGED SHOULD YOU HAVE TO USE AN OUTSIDE COLLECTION SOURCE. IF AN ATTORNEY REPRESENTS ME, I AGREE THAT I AM RESPONSIBLE FOR ANY BALANCE REGARDLESS OF WHETHER OR NOT THERE IS A SETTLEMENT. I have read all the information on this sheet and have completed it to the best of my ability. I certify this information is true and I will notify you of any changes in my status on the above information.

Signature: _____ Date: _____

Parent (if minor) _____ Date: _____



Professional Therapy Services, LP
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HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) 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.

1. Uses and disclosures of Protected Health Information

Uses and Disclosures of Protected Health information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for their purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

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, For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you, 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.

Payment: Your protected health information will be used, as needed, to obtain payment for health care services. For example, obtaining approvals for a hospital stay may require that your relevant protected health information be disclosed to health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students and Licensing, conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school 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 and indicate your physician we may also call you by name in the waiting room when your physician 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.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, public Health issues as required by law, communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, law enforcement, Coroner, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers’ Compensation, Inmates, Required Used and Disclosures, Under the law, we musty 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 there requirements of Section 164-500.

Other Permitted and Required Uses and Disclosures Will be Made Only With Your Consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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Revised: 9/28/05

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you can 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.

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 operations. 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 this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician 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. You then have the right to use another Healthcare Professional.

You have the right to request and receive confidential communications from us by alternative means at any alternative location. You have the right to obtain a paper copy of this notice from us, upon request. Even if you have agreed to accept this notice alternatively i.e. electronically.

You may give the right to have your physician amend your protected health information. If we deny your request for 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.

You have the right to receive an accounting of certain disclosures we have made, if any of your protected health **Information.** We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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.**

This notice was published and becomes effective on/or before **April 14,2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature _____ Date _____

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PATIENT CONSENT TO TREATMENT
&
APPOINTMENT CANCELLATION POLICY

PATIENT CONSENT

My diagnosis, evaluation findings and therapy recommendations will be explained to me in detail by the therapist. I have the right to ask questions, consent or refuse treatment (all or in part) at any time without this affecting the quality of care I will receive.

By signing below, I give consent to receive therapy to reach my goals and may revoke this in writing at any time. I understand that my aims can only be accomplished with regular attendance and if I comply with the instructions given, including my home program.

CANCELLATION FEE *****

The success of your therapy here requires that you comply with the treatment schedule your doctor and therapist have specified. Should you cancel or fail to show up for an appointment, another patient who could have come in, also missed out on that visit.

We understand that certain events are unforeseen, but it is required that we receive 24 hours notice of any changes to your schedule. **A \$25.00 charge will be applied to your account if we do not receive notice of the changes in a timely manner.** Should you cancel or not show up for 2-3 appointments, your physician will be notified and in addition to the above charge, it may result in termination of your therapy, which may affect your recovery.

I have read and understand this advance notice of discontinuation of services and I will make every effort to show up in a timely manner.

Signed _____ Date _____



Professional Therapy Services, LP "Your Preferred Physical Therapy Provider"

FINANCIAL POLICY

Thank you for choosing Professional Therapy Services as your health care provider. We are committed to providing you the best available medical care. Our billing department will be available to discuss our fees and this policy with you if you have any questions. We ask that all responsible parties read and sign our financial policy as well as complete the patient information form prior to seeing the Physical Therapist. Payments for services are due at the time services are rendered. We accept cash, checks, Visa, MasterCard, and Discover. We will be happy to help you file your insurance claim for reimbursement. In special instances, we may not accept assignment for insurance benefits. However, you must understand that: **(PLEASE INITIAL THE FOLLOWING)**

- _____ 1. Your insurance policy is a contract between you, your employer and the insurance company. We are **NOT** party to that contract. Our relationship is with you, not your insurance company. We cannot become involved in disputes between you and your insurance regarding deductibles, co-payments, covered charges, secondary insurance and "usual and customary" charges. Our involvement will be limited to supplying factual information to facilitate claim processing.
- _____ 2. All charges are your responsibility whether you're insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
- _____ 3. Fees for these services, along with unpaid deductibles and co-payments, are due at the time of service.
- _____ 4. If your insurance company does not pay the claim within 45 days, it is your responsibility to contact your insurer to expedite payment. However, if your insurance should pay your claim and you are due a refund, under Normal circumstances processing the refund may take up to but not exceed, six months. However, if our office finds you have an outstanding balance, our office will apply your credit to that balance, the difference, if any will then be refunded to the patient.
- _____ 5. Returned checks and unpaid balances may be subject to collection placement, and collection fees. The returned check fee is \$25.00.
- _____ 6. Should full payment not be made by third party payers, I understand that I will be responsible for payment of services rendered to me. The usual and customary charges may be negotiable. If I am liable for any portion of the payment, I agree to pay the amount due within ten days of receipt of invoice. I understand that services can be terminated if payment is not received as agreed. In the event it becomes necessary to turn this account over to collections, I acknowledge that a collection fee of \$200.00 and any other related costs, including reasonable attorney fees will be added to the total balance of the account. I understand that finance charges can be applied to all amounts that are at least thirty days past due at a rate of one and one half percent (1.5%) per month (18% annual rate).

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us so that we may assist you to keep your account in good standing.

Again, thank you for choosing Professional Therapy Services as your preferred physical therapy provider. We appreciate the trust in us and we appreciate the opportunity to serve you.

Guarantor's Signature _____ Date _____



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ASSIGNMENT OF BENEFITS/
ACKNOWLEDGEMENT OF CO-PAY

I, the undersigned, do hereby authorize and demand the assignment of all medical benefits, include major medical benefits to which I am entitled, including Medicare and other government sponsored programs, private insurance and any other health plans to Professional Therapy Services.

I, the undersigned, do acknowledge that I have been informed by Professional Therapy Services that there will be a \$ _____ co-payment due for each visit. I agree to pay the required co-payment at the end of each visit. I understand I am financially responsible for all charges whether or not they are paid by said insurance. I hereby authorize Professional Therapy Services to release all information necessary to secure payment by my insurance company. I acknowledge I am ultimately responsible for all charges incurred and any balance remaining after insurance has paid.

I hereby authorize Professional Therapy Services to disclose or obtain all or any part of my or my dependent’s records to or from any person or corporation which may be liable for all of part of the charges of Professional Therapy Services including, but not limit to, insurance companies, worker’s compensation carriers, or employers.

Signature
Patient/Parent or legal Guardian

Date

Witness/LPT Staff

Date

IN CASE OF EMERGENCY, PERSON TO BE NOTIFIED:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____ HOME# _____

WORK/OTHER#: _____

Have you ever received physical/occupational/speech therapy during this calander year?
Y/N If so, which service and where? _____



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STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED
HEALTH INFORMATION

Information to be used or disclosed

The information covered by this authorization includes:

Medical Records

Persons authorized to use or disclose information

Information listed above will be used or disclosed by: *Professional Therapy Services, LP*

Name of person or organization

Name of person or organization

Persons to whom information may be disclosed

Information described above may disclosed to:

Name of person or organization

Name of person or organization

Expiration date of authorization

This authorization is effective through ____/____/____ unless revoked or terminated by the patient or the patient’s personal representative.

Right to terminate or revoke authorization

You may revoke or terminate this authorization by submitting a written revocation to Professional Therapy Services (PTS). You should contact the Compliance Officer to terminate this authorization.

Potential for re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature

Name of Patient (print or type)

Signature of patient

Date

Signature of patient representative

Relationship of patient representative to patient

Notifier(s): **Professional Therapy Services**

Patient Name:

Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

If your insurance doesn't pay for Items or Services below, you may have to pay. Your Insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance may not pay for the Items or Services below.

<u>Items or Services</u>	<u>Reason Insurance May Not Pay:</u>	<u>Estimated Cost:</u>
t-band, & electrodes	"Your insurance does not pay for these services"	\$5.00 to \$8.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **Items or Services** listed above.
- **Note:** If you choose Option 1 or 2, we may help you to use any other Insurance that you might have, but your insurance cannot require us to do this.

(G) OPTIONS: Check only one box. We cannot choose a box for you.

OPTION 1. I want the Items or Services listed above. You may ask to be paid now, but I also want my insurance billed for an official decision on payment, which is sent to me on a Insurance Summary Notice. I understand that if my insurance doesn't pay, I am responsible for payment, but **I can appeal to my insurance.** If my insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

OPTION 2. I want the Items or Services listed above, but do not bill my insurance. You may ask to be paid now as I am responsible for payment.

OPTION 3. I don't want the Items or Services listed above. I understand with this choice **I am not responsible for payment, and I cannot appeal to see if my insurance would pay.**

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:

Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.