Professional Physical Therapy & Sports Medicine

WELCOME

Mission Statement:
<u>We treat every patient that comes into our clinic better than we, ourselves, would want to be treated.</u>

As a new patient, we would like to acquaint you with some of our office policies:

Please be aware that if your insurance company requires pre-authorization or pre-certification in order to qualify for treatment coverage, it should be done before any physical therapy treatments are administered. If your insurance company requires a prescription or referral from your physician for physical therapy coverage, you must present that at the time of your initial visit to our clinics. If the prescribed time limits on your referral expire while you are still receiving physical therapy treatments, please contact your physician to obtain updates as necessary for your insurance coverage to remain in effect.

Our office is staffed to assist you with the billing of your insurance company for the payment of your physical therapy treatments as benefit to you. We are also willing and ready to answer any questions that you may have about the coverage benefits that your insurance does, or does not, allow in regards to your physical therapy treatment benefits within our clinics. However, please understand that the ultimate responsibility of the payment of our services rendered on your behalf is up to you. Every insurance company has variances in their coverage policies and protocols. We will contact your insurance company to help you understand how those policies directly affect your individual coverage, but we recommend that you become familiar with your insurance policy in order to better understand your coverage benefits.

If your insurance company requires a co-payment for your office visits, we require that you pay that in our clinics the time of service. We accept personal checks, cash, Visa, Discover, and Mastercard.

If you are unable to keep your scheduled appointment, we request that you contact the clinic where you are scheduled to be treated at least 24 hours in advance of your appointment to reschedule. A $20 fee will be assessed to your account if you fail to show for a scheduled appointment.

If you do not have insurance that covers physical therapy treatments, we request that you pay for your treatment at the time that the service is rendered. Our office managers can also assist you with setting up a helpful and convenient payment plan.

If you ever have any questions or concerns regarding your account, our friendly and knowledgeable billing staff are able to assist you. Our billing department hours are Monday thru Friday from 8 am to 5 pm.

I have read, understand and agree to the policies of Professional Physical Therapy & Sports Medicine as stated above.

Signed: ____________________________________ Date: ______________________

PATIENT INFORMATION **PROFESSIONAL PHYSICAL THERAPY & SPORTS MED**

PLEASE PRINT CLEARLY

Last name of patient _________________________________ First _________________________________

Address _____________________________________ City & State ______________ Zip Code __________

Home # __________________ Work # _______________ Cell # _____________ Age ____ Married/Single

E-mail Address: ____

Social Security # ______________________________ Male/Female Birth Date ___/___/___ (MM/DD/YYYY)

Referring Physician ___________________________ Primary Physician ____________________________

Employer ____ Occupation ____________________________

Date of Injury ___/___/___ How and where were you injured? _____________________________________
____

What is your biggest complaint? ____

What increases your pain? ____

What decreases your pain? ____

What medications are you currently taking? ____

How did your hear about us? ____

Rating your pain on a scale of 1 to 10 with 10 being the most painful, circle where your pain is:

0 1 2 3 4 5 6 7 8 9 10

PRIMARY INSURANCE INFORMATION

Policy holder's name _______________________________________Policy holder's date of birth __/__/___

Employer ________________ Work # ______________ SS # ______________ DL # __________________

Patient's relationship to policy holder ___________________ Insurance Company ____________________

Insurance Phone # ______________________ ID # ____________________ GRP # ___________________

SECONDARY INSURANCE INFORMATION

Policy holder's name _______________________________________Policy holder's date of birth __/__/___

Employer ________________ Work # ______________ SS # ______________ DL # __________________

Patient's relationship to policy holder ___________________ Insurance Company ____________________

Insurance Phone # ______________________ ID # ____________________ GRP # ___________________

OFFICE USE ONLY

Diagnosis Code: 1.____________ 2. _____________ 3. _______________

Person Responsible For Payment of Account

(If different from Insured)

Last Name ________________________________ First Name ________________________________

Address ____________________________ City _____________ State _______Zip Code _________

Relationship to patient ___________________________________ Phone Number ________________

In case of emergency contact (Name and Phone #) ____

POLICY ON PAYMENT AND AUTHORIZATION FOR PHYSICAL THERAPY TREATMENT

All medical care is due and payable when complete unless prior arrangements have been specifically made. A "Repeat Billing Charge" will be added to all accounts to defray the cost of sending repeat statements. Your account will also be charged interest in the amount of 1.5% per month on balances over 30 days. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and overly agree to pay all costs incurred in said unpaid balances. Should there be just cause to turn your account over to a collection agency an additional 33% will be added to your account including collection and legal fees.

I/We so herby consent to and authorize the performances of all treatments and services by the Physical Therapist and staff, which may deem advisable and agree to pay for all treatments and services performed. I also herby authorize release of information requested of my insurance company and/or its representative. I also direct my insurance company to send payments directly to professional P.T. I fully understand that this agreement of consent will continue until canceled by me in writing.

I hereby instruct the above named Insurance Company to pay by check made out and mailed directly to:
Professional Physical Therapy & Sports Medicine
1325 South 800 East Suite 215
Orem, UT 84097

For professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. THIS IS A DIRECT ASSIGNEMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above professional for non-covered service and/or fees, over and above the insurance payment or as required by my insurance policy.

A photocopy of this assignment shall be considered effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance. I also agree to pay for any services rendered beyond any authorized visits from my insurance company.

Date ________________________ Signed ____

Deductible ___________________ Co-Pay (per office visit) ______________________ Coverage% __________________

An $8.00 fee will be added to my account if copays are not paid at the time of service and it becomes necessary to send a statement requesting payment on my account.

Methods of payment we accept are as follows: Cash, Check, Visa, MasterCard and Discover.

HIPAA NOTICE OF PRIVACY PRACTICES

Professional Physical Therapy & Sports Medicine
1325 South 800 East Suite 215
Orem, UT 84097
801-373-1053

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUTH YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of privacy describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or 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, which may identify you and that, relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physical therapist, our office staff and others outside of our office that are involved in your care and treatment for the purposes of providing health care services to you, to pay your health care bills, to support the operation of the physical therapists practice, and may 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 information, a necessary, to a physician to whom you have been referred to our office by to ensure that the physician ha the necessary information to update your records. 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 from your health care services. For example, obtaining approval for physical therapy treatments may require that your relevant protected health information be disclosed to health plan to obtain approval for treatment.

Healthcare Operations: We may use or disclose as needed, your protected health information in order to support he business activities of your physical therapist's practice. These activities include, but are not limited to quality assessment activities, employee review activities, training of interns, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to interns 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 our 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.

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: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security Workers Compensation: Inmates: Require 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 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 physical therapist or physical therapist's practice has taken action in reliance on the use or disclosure indicated in authorization.

I HAVE BEEN NOTIFIED OF THE HIPAA PRIVACY PRACTICES BY PROFESSIONAL PHYSICAL THERAPY AND SPORTS MEDICINE.

Date: ____________________________ Signed: ____