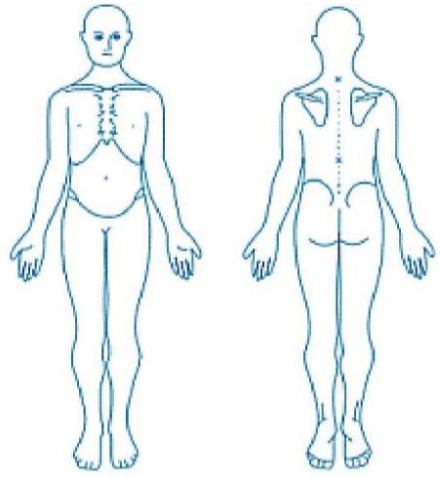
SOUTHLAND PHYSICAL THERAPY

Name: _____ Date: _____ Age: _____

Occupation or previous occupation: _____

Physical Therapy Subjective Information Record

Area(s) of Injury



A. Shade in all areas of your symptoms, pain, stiffness, aches, etc. on the drawing to the right.

B. Label the spot of your worst pain with a large X.

C. Circle any areas of numbness or tingling.

D. When did your injury occur? ____/____/_____

E. If post op, when was your surgery? ____/____/_____

F. From 0-10, if 0 = no pain, 10 = maximum pain:
Current pain level: ____/10,
Worst pain level: ____/10, Least Pain level: ____/10

G. Height: ____ ft _____ in Weight: _____ lbs

Medical Questions - (circle yes/no):

1. **Yes/No** Do you have a pacemaker?
2. **Yes/No** Have you experienced significant weight loss recently?
3. **Yes/No** Have you ever had cancer?
4. **Yes/No** Have you had multiple cortisone or prednisone injections?
5. **Yes/No** Are you taking any anti-inflammatory medications?
6. **Yes/No** Are you taking any muscle relaxants for this problem?
7. **Yes/No** Are you taking any pain medications for this problem?
8. **Yes/No** Are you currently taking any other medications?
   a. Please list in chart
9. **Yes/No** Do you have any difficulties with urination?
   a. If yes, please explain: _____
   _____
10. What other health care providers are you currently seeing? _____
    _____
11. Have you had any of the following for this specific problem (circle yes/no):
    Yes/No CT Scan
    Yes/No MRI
    Yes/No X-ray

Medication	Dosage	Frequency

Is there any condition not listed above that you feel may affect your treatment in any way (please circle): heart condition, lung condition, osteoporosis, joint replacements, balance deficit, visual impairment, previous surgeries, skin sensitivity, allergies, dizziness, fainting? Please explain: _____
_____
_____

I acknowledge that the above information I have written is true and accurate to the best of my knowledge. I will notify my therapist of any change in condition.

_____ _____/_____/_____

Patient Signature Date

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PATIENT INFORMATION

LAST _____ FIRST _____ MI _____

GENDER _____M _____F BIRTHDATE_____MO./_____DAY/_____YEAR SS# _____-_____-_____

ADDRESS _____ CITY_____ ST_____ ZIP _____

PHONE (CELL) _____ PHONE (HOME) _____

EMAIL _____ MARITAL STATUS _____

EMPLOYER _____ ADDRESS_____

OCCUPATION _____ WORK PHONE _____ EXT _____

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____ WHAT IS YOUR CO-PAY? _____

LEAVE A MESSAGE AT YOUR: □ HOME □ OFFICE □ EMAIL / TEXT MSG □ OTHER _____

EMERGENCY CONTACT

LAST _____ FIRST _____ RELATIONSHIP _____

PHONE (CELL) _____ PHONE (HOME) _____

REFERRAL SOURCE

1. HAVE YOU BEEN A PATIENT HERE BEFORE? YES OR NO (CIRCLE ONE)
2. WHO MAY WE THANK FOR REFERRING YOU? (FILL IN BELOW)
   - DOCTOR / REFERRING CLINICIAN:_____
   - FAMILY MEMBER/FRIEND:_____
   - INSURANCE:_____
   - INTERNET SEARCH:_____
   - OTHER:_____

INSURANCE: PRIMARY PLEASE COMPLETE ALL INSURANCE INFORMATION COVERING THE PATIENT

IF PATIENT IS NOT THE PRIMARY INSURED PLEASE INDICATE BELOW.

PRIMARY INSURED NAME_____

SS# _____ BIRTHDATE____MO./_____DAY/_____YEAR

CIRCLE RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD OTHER_____

INSURANCE: SECONDARY PLEASE COMPLETE ALL INSURANCE INFORMATION COVERING THE PATIENT

IF PATIENT IS NOT THE PRIMARY INSURED PLEASE INDICATE BELOW.

PRIMARY INSURED NAME_____

SS# _____ BIRTHDATE____MO./_____DAY/_____YEAR

CIRCLE RELATIONSHIP TO PATIENT: SELF SPOUSE CHILD OTHER_____

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Name: _____

Appointment Reminder Consent

Complete this form and sign below to give your permission for Southland Physical Therapy to provide automatic appointment reminder service by email or by cell phone text message as of **June 27, 2016.**

Select One Option Below:

☐ Southland Physical Therapy may send email messages to confirm my upcoming appointments to:
_____.
(Patient Email)

☐ Southland Physical Therapy may send cell phone text messages to confirm my upcoming appointments to:
_____.
(Patient Cell Phone Number)
I recognize that normal text messaging rates may apply.

NOTE: If you would like text messages instead of email reminders, please indicate your Cell Phone Carrier.

We cannot set your account up to send email text message reminders without knowing your cell phone carrier. Please indicate your carrier below, if you would like text message reminders:

- ☐ ALLTel
- ☐ AT&T
- ☐ Boost Mobile
- ☐ Cingular
- ☐ Cricket Wireless
- ☐ Metrocall
- ☐ MetroPCS
- ☐ Nextel
- ☐ Qwest
- ☐ Sprint PCS
- ☐ T Mobile
- ☐ US Cellular
- ☐ Verizon
- ☐ Virgin Mobile

_____

Signature of Patient or Guardian

_____

Date

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PATIENT CONSENT

I consent to any medical treatment rendered under the general and special instructions of the physician and/or physical therapist.

I agree to be evaluated and treated for functional loss due to related nerve, muscle, and skeletal dysfunctions and/or pain.

I understand that therapeutic procedures can include, but are not limited to: joint and soft tissue mobilization, home exercise programs, therapeutic exercises, neuromuscular education, gait training, functional training including: posture and body mechanics, modalities, such as heat, ice, electrical stimulation, ultrasound, laser, and special procedures such as: taping, neuromuscular electrical stimulation, mechanical traction, and bladder training.

I understand that I may refuse any therapeutic procedure or treatment at any time.

_____ _____ _____

Patient Name (Print) Signature Date

PATIENT RESPONSIBILITY & APPOINTMENT POLICY

Our commitment to our patients is to provide the utmost care and professionalism for your physical therapy treatment, in order to help you restore your quality of life, replenish your spirit, and rejuvenate you back to wellness. Your responsibility as the patient is the adherence to the recommended number of treatments, which is a significant component for your progress with physical therapy.

In light of this, it has always been our policy here at Southland Physical Therapy, to give our patients the benefit of the doubt when they forget to show up for an appointment or cancel an appointment with less than 24 hours notice. However, 3 "no-shows" (missed appointments without any prior notification) OR cancellations less than 24 hours in advance, combined, may result in the loss of your physical therapy benefits. We are obliged to notify your referring physician about attendance or compliance problems and your physician may decide to discontinue your course of therapy.

In addition, based on our No-Show or Cancellation Less Than 24 Hours in Advance Policy: We reserve the right to charge a $25 fee for a missed appointment or cancellations less than 24 hours. This charge will not be covered by insurance, but will have to be paid by you personally. Even if it is a last minute cancellation, we would greatly appreciate you notifying us.

The main reason for this policy is that missed appointments create a hardship and interrupt the continuity of your care and other patients. There may be patients awaiting appointments who are in need of a treatment or evaluation, and they cannot always come in with less than 24 hours notice.

Your commitment to attending your appointments, being here on time, and doing your home exercise program is critical for your recovery.

I understand and agree with the above policy and I will do my best to adhere to it.

_____ _____ _____

Patient Name (Print) Signature Date

_____ _____ _____

Responsible Party (if Not Patient) Signature Date

SOUTHLAND 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 this policy carefully.

Understand your health record and information:

When receiving physical therapy services from SOUTHLAND PHYSICAL THERAPY, INC. a record is made of your treatment. This record contains your symptoms, diagnoses, examinations, assessments, evaluation, and your treatment plan. It also contains daily treatment notes and progress notes. This record is referred to as your medical record and serves as a:

- Basis for planning your care and treatment
- Means of communication among the health professionals who contribute to your care
- Legal document describing the care you receive
- Means by which services can be verified for billing purposes
- A tool for education of physical therapy professionals
- A source of data for facility planning
- A tool with which the quality and outcome of care and services given can be evaluated

Our pledge regarding medical information:

We understand that medical information about you is personal and we are committed to protecting this information. We create a record of care and services you receive. This record is needed to provide you with quality care and to comply with certain legal requirements. This notice applies to the records for your treatment.

How we may use and disclose your medical information:

1. **For treatment:** we may use medical information about you to provide you with treatment. We may disclose this information to your doctors, or other personnel who are involved in your treatment.
2. **For payment:** we may disclose medical information about you so that the treatment you receive may be billed to and payment may be collected from insurance or other benefits that you may be entitled to.
3. **Review for quality care:** we may disclose medical information about you for internal quality check to make sure all of our patients receive quality care.
4. **As required by law:** we will disclose medical information about you when required to do so by federal, state, or local law.
5. **Lawsuits and disputes:** if you are involved in lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Transferring of records:

If for any reason, you would like a copy of your entire record, please make your request in writing. For your protection, please have proper ID with you if picking up records in the office.

I have read and understand the information outlined above.

_____	_____	_____
Patient Name (Print)	Signature	Date
_____	_____	_____
Responsible Party (if Not Patient)	Signature	Date

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FINANCIAL RESPONSIBILITY POLICY

As the patient, it is in your best interest to know and understand your insurance plan's benefits, including responsibility for any deductibles, co-insurance or co-pay amounts prior to any visit. Regardless of your individual insurance coverage, as the person seeking medical treatment, you are ultimately responsible for all charges. You are required to provide all information necessary so that we may process your claims in a timely and efficient manner. If your insurance coverage changes during the course of your treatment, you are required to notify us immediately of that change and provide all information necessary in order to avoid delay and/or denial of payments.

Please know that we are here to help you if you have any questions!

IN-NETWORK INSURANCE - We will attempt to acquire accurate and complete insurance benefit information at your first visit. If you have a co-pay, you are required to make the payment at the time of service. If your policy requires a deductible or co-insurance, we will attempt to estimate your patient portion per your insurance company. If you have a balance due, you will be billed accordingly upon receipt of benefits for your insurance company. In the event of an overpayment, you will be reimbursed once all claims have been paid. Please understand, we cannot reduce or waive your co-pay or co-insurance. If you have a financial hardship or difficulty with your payments, please speak with the clinic manager for your options.

INSURANCE CHANGES DURING YOUR COURSE OF TREATMENT – If your insurance should change during the course of treatment, please provide your new insurance information prior to your next appointment, as this is your responsibility. Numerous insurance companies require authorization that may not be backdated for any reason. If there is a time lapse between the effective date of your new policy and you informing the clinic of this fact, you may be responsible for any claims that are denied for any reason including lack of referral and/or authorization.

OUT-OF-NETWORK INSURANCE - We will attempt to acquire accurate and complete insurance benefits information at your first visit. If we are not "in-network" with your insurance company there may be "out-of-network" benefits with different co-pays and co-insurance. You will be responsible for payment in full at the time of service. You may speak with our billing staff about cash discount rates, and/or payment plans.

NO INSURANCE - If you are not insured, payment will be expected in full, at the time of service. The front office can provide you with our cash rate fees as well as answer any questions.

MEDICARE - Medicare allows $1960 for Physical and Speech Therapy combined, per calendar year. Occupational Therapy has a separate allowance of $1960. This payment amount may also subject to your $166 Part B annual deductible. **Please let us know if you have had therapy already this calendar year, as this will potentially impact the amount of coverage you have. All benefits will be verified. Please notify us immediately if you are receiving home healthcare. Medicare does not allow you to have outpatient physical therapy in conjunction with any home healthcare.**

WORKERS COMPENSATION CLAIMS - It is the responsibility of the patient to give all information required for processing/obtaining authorizations and claim payment. This information shall include (but may not be limited to) your employer, date of injury, SSN, name of adjuster or case worker, case/claim number, contact phone number, and the insurance company address. Prior authorization must be obtained by the patient prior to being evaluated. In the event the claim is denied, you will be responsible for payment of any rendered service in full.

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MVA- MEDPAY COVERAGE - Please note that it is NEVER a guarantee that auto insurance will pay for your physical therapy services. Payment is based on medical necessity and review by the insurance company. If you are being treated as the result of a motor vehicle accident, we are required to go through any medical coverage you may have on YOUR automobile policy (regardless of who was at fault) before going through your health insurance. You will be required to provide this office with the date of injury, your SSN, name of adjuster or case worker, case/claim number, contact phone number and insurance company address, and amount of medical coverage on your policy. You will need to track how much of your benefits have been used. We HIGHLY recommend that patients have/provide their OWN medical insurance as secondary coverage in case the MVA insurance denies payment to our facility.

LIEN CASES - Our office policy requires the following information to be obtained before treatment is rendered: the date of accident, name/number/fax of the lawyer complying with your case, YOUR medical insurance information, details of the accident/incident, and the required prescription from a medical doctor. A Lien Agreement must be signed by the patient and lawyer and returned to our office via mail or fax. If your case is not ruled in your favor, you will be held financially responsible for any and all balances left on your account.

MINOR PATIENTS - The adult consenting treatment for the minor patient will be held financially responsible for services rendered.

PAST DUE ACCOUNTS - If your account becomes past due, we will take necessary steps to collect this debt. We will do our best to help you in any way we can, and will contact you about outstanding fees before taking further action. If no response is given to our office in a matter of one weeks' time since the courtesy phone calls and messages were left, your account will be referred to our collection agency. You will be charged for this service in addition to your current account balance. If payment is not received, your credit report will be blemished.

RETURNED CHECK FEE - There is a $35.00 fee for any check returned by the bank for insufficient funds.

I hereby assign all physical therapy benefits to Southland Physical Therapy for services rendered to me or said minor patient. I authorize any holder of medical information about me or said minor to release to my insurance company any information needed to determine these benefits payable for related services. I understand that if my insurance benefits and/or eligibility DO NOT COVER OR APPROVE PAYMENT FOR SERVICES PROVIDED BY SOUTHLAND PHYSICAL THERAPY, I AM FINANCIALLY RESPONSIBLE AND AGREE TO PAY FOR ALL CHARGES RELATED TO SERVICES RENDERED. This includes, but is not limited to; services deemed 'non-covered' or 'not medically necessary' by my insurance.

I understand my signature requests that payment be made to Southland Physical Therapy, and authorize release of medical information necessary to pay the claim.

I have read and understand the financial policy and I agree to adhere to its terms. Altering this form in any way will not change the policy as outlined above by Southland Physical Therapy.

_____	_____	_____
Patient Name (Print)	Signature	Date
_____	_____	_____
Responsible Party (if Not Patient)	Signature	Date