

PATIENT INFORMATION FORM

Name \_\_\_\_\_

Street Address \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Social Security Number \_\_\_\_\_ Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Marital Status ( ) Married ( ) Separated ( ) Widowed ( ) Single ( ) Divorced

Name of Person to Contact in Case of Emergency \_\_\_\_\_

Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Your Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Work Address \_\_\_\_\_ Work Phone \_\_\_\_\_

Student at \_\_\_\_\_ Full-Time \_\_\_\_\_ Part-Time \_\_\_\_\_

Name of Spouse \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security # \_\_\_\_\_

Spouse's Occupation \_\_\_\_\_ Spouse's Employer \_\_\_\_\_

Spouse's Work Address \_\_\_\_\_ Work Phone \_\_\_\_\_

If you are under 18 years of age, who are your legal parents or guardians?

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Name of Doctor Who Referred You to Us \_\_\_\_\_ Date of Next Appointment \_\_\_\_\_

Did the condition or injury result from an *automobile accident*? ( ) YES ( ) NO

Did the injury result from a *work-related accident* to be filed with workers compensation? ( ) YES ( ) NO

Approximately, when did your injury or condition occur? \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Surgery (if applicable) \_\_\_\_/\_\_\_\_/\_\_\_\_

Please indicate other healthcare providers you have seen for this injury/condition, and when you last saw them:

Name: \_\_\_\_\_ Type of Practice: \_\_\_\_\_ Date of Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_ Type of Practice: \_\_\_\_\_ Date of Visit: \_\_\_\_/\_\_\_\_/\_\_\_\_

What operations, serious illness or conditions have you had? \_\_\_\_\_

What medications or drugs are you taking: \_\_\_\_\_

- Have you ever suffered from:
\_\_ Dizziness \_\_ Arthritis \_\_ Digestive Disorders \_\_ Backaches
\_\_ Headaches \_\_ Nervousness \_\_ Heart Trouble \_\_ Numbness \_\_ High Blood Pressure \_\_ Cancer
\_\_ Diabetes \_\_ Asthma \_\_ Anemia \_\_ Hernia \_\_ Neuritis

WOMEN ONLY: Are you pregnant or is there any possibility you may be pregnant? ( ) YES ( ) NO ( ) UNCERTAIN

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## ASSIGNMENT OF PROCEEDS

I hereby give my permission to Williams Physical Therapy to treat me, or, \_\_\_\_\_, who is a minor. I understand and agree that health and accident insurance policies are an arrangement between my insurance company and myself, not between my insurance company and this office. I agree to pay my estimated co-pay at the time services are rendered, including any deductibles, and further understand that the estimated co-pay is neither a guarantee of payment by my insurance company, nor necessarily an accurate reflection of my actual co-pay as determined by my insurance company upon processing of my claims. In the event that my insurance company does not pay on my charges at the estimated rate or within a reasonable period of time, upon request of this office I will immediately pay the balance owing on my account. If not immediately paid, interest at a rate of 1½% per month or the maximum allowable by law, whichever is greater, may accrue on the outstanding balance until the balance is paid in full. I agree to pay at least 10% of the outstanding balance on my account monthly until the balance is paid in full, unless otherwise agreed on by Williams Physical Therapy.

I hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities ("payers"), which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illnesses, past or future ("condition"), to pay directly to, and exclusively in the name of Williams Physical Therapy (WPT) such sums as may be owing to WPT for charges incurred by me, including but limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at WPT. I further grant a contractual lien to WPT with respect to my charges, however, nothing in this Agreement shall be construed as an election of remedies under any statutory lien law. Furthermore, in the event of a conflict between the assignment and the grant of contractual lien, the assignment shall control. For the purposes of this Agreement, "benefits" shall include, but shall not be limited to, proceeds from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, disability benefits, worker's compensation benefits, medical payment benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, attorney retainer agreements, and any other benefits or proceeds payable to me for the purposes stated herein, regardless of whether such proceeds are related to my charges or not.

I further agree that, in the event a payer refuses to pay WPT pursuant to this Agreement, I hereby assign, insofar as permitted by law, all of my rights, remedies, and benefits to WPT to extent of my charges, as well as any and all causes of action that I might have against such payer, to prosecute such causes of action either in my name or in WPT's name, and to settle or otherwise resolve such causes of action as WPT sees fit.

In the event that I retain one or more attorneys to represent me in this matter, I will direct each attorney to issue a letter of protection to WPT regarding my charge. Upon issuance, I hereby agree that such letter(s) of protection cannot be revoked or modified without the expressed written consent of WPT. I further direct each attorney to provide immediate notice to WPT regarding any funds received by the attorney relating to my accident, to promptly pay WPT, and to provide a full accounting of such funds to WPT upon its request.

I hereby direct all payers to release to WPT any information regarding any coverage of benefits which I may have including, but not limited to, the amount of the coverage, the amount paid thus far, and the amount of any outstanding claims.

I authorize WPT to release any information regarding my treatment or pertinent to my case(s) to all payers as defined above to facilitate collection under this Agreement. I hereby direct WPT to file a copy of this Agreement, together with any applicable charges, with any or all payers, regardless of whether a claim has been established with said payers. I hereby authorize WPT to endorse/sign my name on any and all checks listing me as a payee which are presented to WPT for payment of an account relating to me, my spouse, or any of my dependents. I further authorize WPT to apply any credit balances on charges incurred by me to any other outstanding charges still owed by me, my spouse, or my dependents, regardless of whether these other charges are related to my condition.

I understand that I remain personally responsible for the total amounts due WPT for their services. This Agreement does not constitute any consideration for WPT to await payments and it may demand payments from me immediately upon rendering services at its option. If WPT must take any action to collect an outstanding balance on my accounts, I will be responsible for payment and will reimburse WPT for all costs of such collection efforts, including, but not limited to, all court costs and all attorney fees.

I also acknowledge that if I am filing worker's compensation, coverage may be jeopardized if I do not comply with my physician's and/or therapist's recommendations regarding treatment (i.e., keeping appointments). Because of this I acknowledge full financial responsibility for services rendered by Williams Physical Therapy should my worker's compensation be denied. I acknowledge that my therapy progress may be discussed with my worker's compensation case worker, if applicable.

This Agreement shall not be modified or revoked without the mutual, written consent of WPT and myself. I hereby revoke any previously signed authorizations, whether executed at WPT or any other office to the extent that the terms of those authorizations conflict with the terms of this Agreement.

I agree that each and every provision of this Agreement is reasonably necessary for the protection of the rights and interests of WPT and myself. However, should any provision of this Agreement be found to be invalid, illegal or unenforceable, or for any reason cease to be binding on any party hereto, all other portions and provisions of this Agreement shall, nevertheless, remain in full force and affect.

There will be a \$30.00 "no-show" or cancellation charge, that will be directly charged to the patient and which cannot be billed to insurance, if WPT is not contacted at least 24 hours prior to scheduled appointment. \_\_\_\_\_ (please initial)

Patient Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Name (Please print) \_\_\_\_\_

Parent/Guardian/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Custodial Parent/Legal Guardian/Guarantor (please print) \_\_\_\_\_

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**MEDICARE PATIENTS ONLY**

Have you had any Physical Therapy or Speech-Language Pathology since January 1<sup>st</sup>? \_\_\_\_ yes \_\_\_\_ no

Have you been seen by any Home Health Agency for your current injury/condition? \_\_\_\_ yes \_\_\_\_ no

If yes, name of Agency: \_\_\_\_\_ Date Last Seen \_\_\_\_\_

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**Authorization for signature on file – Medi-gap Benefits**

Name of Beneficiary: \_\_\_\_\_ Medicare Number: \_\_\_\_\_

Medigap Insurance: \_\_\_\_\_

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Galax Rehabilitation Service, Inc. DBA Williams Physical Therapy for any services (current or future) furnished me by that provider. I authorize the release of any medical information about me needed to determine these benefits or the benefits payable for related services.

Signature of Beneficiary \_\_\_\_\_ Date: \_\_\_\_\_

## CONSENT FORM

### (For Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations)

I understand that as part of my healthcare Williams Physical Therapy originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care and treatment. I also understand this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a **Notice of Privacy Information Practices** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand Williams Physical Therapy reserves the right to change their notice and practices, and prior to implementation, will mail a copy of any revised notice to the address that I have provided if there is a need to use or disclose any protected health information. I also understand that I have the right to restrict as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and Williams Physical Therapy is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Williams Physical Therapy has already taken action in reliance thereon.

With this consent, Williams Physical Therapy may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment or healthcare operations, such as appointment reminders, insurance items and any call pertaining to my clinical care.

With this consent, Williams Physical Therapy may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment or healthcare operations, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Williams Physical Therapy may e-mail to me appointment reminder cards and patient statements. I have the right to request that Williams Physical Therapy restrict how it uses or discloses my protected health information to carry out treatment, payment or healthcare operations. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Williams Physical Therapy the use and disclosure of my protected health information to carry out my treatment, payment or healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. **If I do not sign this consent, Williams Physical Therapy may decline to provide treatment to me.**

Print Patient Name: \_\_\_\_\_

Signature of Patient or Legal Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

*This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.*

**NOTICE OF PRIVACY INFORMATION PRACTICES**

Effective Date: 04/14/03

1. Williams Physical Therapy staff members may use your protected health information or disclose protected health information to other health professionals for the purpose of evaluating your health, diagnosing and treating medical conditions, and providing health care options.
2. Your protected health information may be used to seek payment from, but are not limited to your health plan, other sources of coverage including insurance companies for claims, including coordination of benefits with other insurers, collection agencies, automobile insurers and credit card companies that you may use to pay for services.
3. Your protected health information may be used as necessary to support day to day activities in management of Williams Physical Therapy including, but are not limited to, internal quality control and assurances, including auditing of records.
4. Your protected health information is permitted to be used by Williams Physical Therapy when required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances including but not limited to public health requirements or court orders.
5. Williams Physical Therapy will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorization may be revoked at any time. Revocation must be written.
6. Williams Physical Therapy may at times contact the patient to provide appointment reminders or information regarding treatment alternatives or other health-related benefits and services that may be of interest to the individual patient.
7. Williams Physical Therapy will abide by the terms of this notice currently in effect at the time of the disclosure. Williams Physical Therapy reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains.
8. Williams Physical Therapy will provide each patient with a copy of any revisions of its Notice of Privacy Information Practice at the time of their next visit, or at their last known address if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our offices.
9. Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with Williams Physical Therapy, please contact the Privacy Officer at the following address and/or phone number: Karen Huffman, 106 W. Stuart Drive, Galax, VA 24333 (276) 238-8900.
10. It is Williams Physical Therapy policy that no retaliatory action will be made against any individual who submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.
11. You have certain rights under the federal privacy standards. These include:
  - a. The right to request restrictions on the use and disclosure of your protected health information
  - b. The right to receive confidential communications concerning your medical condition and treatment
  - c. The right to inspect and copy your protected health information
  - d. The right to amend or submit corrections to your protected health information
  - e. The right to receive an accounting of how and to whom your protected health information has been disclosed
  - f. The right to receive a printed copy of this notice
12. You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the receptionist or privacy officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Patient's Name (please print) \_\_\_\_\_

Signature of Patient or Legal Guardian \_\_\_\_\_

Date \_\_\_\_\_