

Saline County Physical Therapy Registration

Personal Information

Last Name First Name Male Female Date

Street Address City State Zip

(____) _____ (____) _____
Home Phone Cell Phone Email Address

_____/____/____
Social Security # Age DOB Single Married Widowed

Occupation Employer (____) Phone #

Parent/Guardian Signature (**If minor**)

My condition is related to: ____ Work ____ Auto Accident ____ Other

Have you had PT, OT, or Chiropractic treatment at any other facility this calendar year? Yes ____ No ____

Work Status: __ Employed __ Retired __ Student __ Disabled (__ Total or __ Temporary)

Emergency Contact (____) Phone #

Referral Information

How did you hear about us?

If by a friend or family member, please give their phone number and address that we may send a thank you note.

OR Primary or Referring Physician Name

Do you have a followup appt. with this physician? If yes, when _____

Payment Information

I am paying by __ Cash __ Check __ Credit

OR

____ I have insurance and would like to have you deal directly with them.

The following information is required prior to 1st visit:

My coinsurance/copay is \$ _____ My deductible is \$ _____

____ Visa __ MC __ AmerX __ Discover Card # _____

Name on Card _____ Exp. Date _____ CVV Code _____

About your current complaint:

What is the complaint that brought you here? _____

When did this complaint begin, or recently become worse? Approx. Date _____

What caused this complaint? _____

Does this complaint affect your activity choice, tolerance, efficiency or effectiveness: Yes No

If "Yes", what activities? _____

What makes this complaint better? _____

Does this complaint affect your comfort, mood, or ability to sleep? Yes No

What symptoms are you experiencing with this complaint?

Swelling Loss of balance or coordination Loss of motion

Numbness Pain Weakness Tingling Other (specify)

How frequent are the symptoms experienced? Constant Intermittent

How much pain are you experiencing? none very mild moderate severe very severe

What tests have you had for this complaint?

x-ray CT scan MRI myelogram bone scan Where this year? _____

What treatment have you had for this complaint?

Physical Therapy Occupational Therapy Athletic Training Chiropractic

Alternative Medicine (specify): _____

Is this complaint work related? Yes No

Work status: Full Time Part Time Working Medical Restrictions Medical Leave

Last date worked: _____

Is this complaint auto related? Yes No City, State of Auto Accident _____

About you general health:

Please check all medical conditions that you **have** or **have had**.

arthritis cancer diabetes stroke/seizure lung disease thyroid problems

stomach disorder anxiety depression panic attacks headaches dizziness

metal implants morning stiffness pacemaker other: _____

Please check all of the following items that **currently** apply to you

hearing problem pregnant visual problem bowel or bladder control learning problems

smoker weight loss

Please list surgeries: _____

Please list allergies: _____

Please list medications you are currently taking: _____

What goals do you want to achieve through your treatment at Saline County Physical Therapy?

Saline County Physical Therapy

Patient Rights

The following is our policy regarding the rights of the patients receiving service for Saline County Physical Therapy. Each patient has the right to:

- Be fully informed of his/her rights as well as all rules and regulations of Saline County Physical Therapy governing patient expectations.
- Be fully informed at the time of admission of services available and related charges not covered under Title XVIII of the Social Security Act.
- Be fully informed by a physician of his/her medical condition unless medically contraindicated, and to be afforded the opportunity to participate in the planning of his/her medical treatment
- Refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.
- Be assured confidential treatment of clinical records and to approve or refuse their release to any individuals, except in the case of transfer to another health care facility, or as required by law or third party payment contracts.
- Be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and care of personal needs.
- Be informed by Saline County Physical Therapy of the provision of the law regarding complaints and of procedures for registering complaints confidentially including, by not limited to the address and telephone number of the complaint receiving unit of the Arkansas Department of Health Services.
- Be assured that personnel who provide care are qualified through education and experience to carry out the services for which they are responsible.
- Be informed that these rights may be denied for good cause only by the attending Physical Therapist. Denial of such rights shall be documented by the attending Physical Therapist in the patient's clinical record.

Saline County Physical Therapy

Dear Patient,

Your insurance may pay your total bill for services rendered at Saline County Physical Therapy. However, it is likely that your insurance will pay some portion of the charge(s). The unpaid portion of the bill is your responsibility. Please contact your insurance carrier directly if you feel your insurance company has underpaid its portion. Please remember that you are responsible for your deductible and co-payment. These are due at each appointment.

Cash Pay Patients: Even though you may have health insurance benefits that would pay all or some portion of your physical therapy charges, you may choose to pay cash for services rendered at Saline County Physical Therapy.

If at any time during the period you are a patient at Saline County Physical Therapy you decide to stop paying cash and start using your insurance benefits you have on of two options:

Option 1. Your insurance will be billed from the date of service you decide to start using your insurance moving forward. Any prior visits paid using cash will not be billed retroactively.

Option 2. If you want your insurance to be billed retroactive to your first date of service, you will pay \$10 for each date of service in the past to cover the administrative costs of retroactive billing.

We believe that you are entitled to the benefits of your insurance plan and we believe the services provided to you by Saline County Physical Therapy are within these benefits. You, as a plan member, are always more successful at dealing with your insurance company directly. Please make an effort to defend your rights as a member in your plan. You deserve the best care possible and you certainly have the right to demand excellent care.

If there is anything we can do to assist you, please do not hesitate to ask for help. Thank you for your cooperation in this matter.

Warm regards,
Saline County Physical Therapy

Important Company Policies for a Successful Relationship

We strive to provide you the best personalized care available. To make this possible we adhere to a set of important guidelines. Please read them carefully, check all the boxes, and indicate your agreement by signing at the bottom.

- Advance Notice Fee**
If you wish to change or cancel an appointment we request a 24-hour advance notice. Anything less may result in a \$25 fee charged to your account. Please be courteous and responsible. Thank you.
- Copays are due upon arrival**
If you happen to forget your wallet or checkbook we may still be able to see you but on your next visit two copays will be due upon arrival.
Important Notice from the Federal Government- "It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments....."
- Cell phones must be shut OFF or silent**
Cell phones can cause problems with sensitive equipment in our office. Please be courteous and set to silent mode or turn off. Thank you.
- Financial Hardship**
If you are experiencing financial difficulties and are unable to afford the cost of our services we have a payment plan available. The billing and collections manager will be glad to talk with you about our plan.
- Children require supervision**

We look forward to building a successful relationship with you that lasts a lifetime!

Signature

Date

Saline County Physical Therapy

Authorization of Release Information

I hereby authorize Saline County Physical Therapy to release any information acquired in the course of my evaluation or treatment for billing purposes.

Signed by the subscriber

I hereby authorize Saline County Physical Therapy to release any information regarding my medical condition to the attending or referring medical practitioner.

Signed by the subscriber

Authorization to Pay Benefits

I direct that payments be made directly to Saline County Physical Therapy. I understand that I am financially responsible for all charges not paid by my insurance. I also understand that all payments made directly to me are to be forwarded to this office.

Signed by subscriber

Please Print Name _____

IF MEDICARE IS YOUR PRIMARY INSURANCE PLEASE READ CAREFULLY AND SIGN BELOW

NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS (NEMB)

- * Medicare does not pay for all of your health care costs. Medicare only pays for covered benefits

- * Medicare has a limit of \$1810 for physical therapy and speech/language pathology combined

If your Medicare limit of \$1810 has been met this year at this facility or another therapy office, you are responsible for any charges incurred after the limit.

Patient Signature

Date

Saline County Physical Therapy

NOTICE OF PATIENT INFORMATION PRACTICES

*** This notice describes how your personal medical information may be used or disclosed and how you can get access to the information. Please review carefully. ***

Saline County Physical Therapy's Legal Duty

Saline County Physical Therapy uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, Saline County Physical Therapy may use your personal health information to contact you to provide appointment reminders, information about treatment alternatives, or other health related benefits that could be of interest to you.

Saline County Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Patient's Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. You may also request in writing that we are not to use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances.

I have read and fully understand this "Notice of Information Practices." I hereby consent to the use and disclosure of my personal health information for purposes as noted. I understand that I retain my right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Signature

Date

*****If you would like a copy of our HIPPA policy please sign below*****

Signature