

Patient Information - Please Print Legibly

Today's Date: _____ Who can we thank for referring you? _____

Last Name: _____ First Name: _____ MI: _____

Mailing Address: _____

City _____ State _____ Zip _____

Cell Phone: _____ Home Phone: _____

DOB: _____ Age: _____ Sex: _____ Single Married Divorced

Patient Social Security Number _____ Student Yes No

Patients Employer: _____ Full Time Part

Time Email _____ Can we contact you through text?

Primary Physician _____

Referring Physician _____

Diagnosis _____ Date of Injury/Onset _____

Spouse/Guardian/Parent Name _____ Relationship _____

DOB _____ Social Security Number _____ Phone _____

Emergency Contact Name: _____ Phone: _____

INSURANCE

Are you the primary subscriber on the insurance? Yes No

If no, who is responsible for this account? _____ DOB: _____

Relationship to Patient _____ Social Security Number _____

Is this a Workers Comp claim? Yes No **If yes**, please fill out the section below

Case # _____ Date of Injury _____

Employer at time of Injury _____

Employer Address _____ City _____

State _____ Zip _____ Phone _____

Case Manager _____ Phone _____

Are you or could you be pregnant? Yes No
 Tobacco Use? Yes No How often? _____
 Allergies: _____

Procedures _____

Surgical Procedures _____

YOUR Medical History Please indicate if **YOU** have a history of the following:

<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> GERD	<input type="checkbox"/> Neuropathy
<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Anxiety Disorder	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Parkinson's
<input type="checkbox"/> Asthma	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> HIV	<input type="checkbox"/> Seizures/Convulsions
<input type="checkbox"/> Blood Clots/DVT	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> Bowel Disease	<input type="checkbox"/> Joint Dislocations	<input type="checkbox"/> Steroid Use
<input type="checkbox"/> Broken or Cracked Bones	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Loose Joints	<input type="checkbox"/> Suicide Attempts
<input type="checkbox"/> COPD	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> TB (Tuberculosis)
<input type="checkbox"/> Concussion/Head Injury	<input type="checkbox"/> Lupus	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Depression	<input type="checkbox"/> Major Traumatic Injury	<input type="checkbox"/> WBS
<input type="checkbox"/> Diabetes Type I	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Other _____
<input type="checkbox"/> Diabetes Type II	<input type="checkbox"/> Migraines	
<input type="checkbox"/> Dementia	<input type="checkbox"/> Multiple Sclerosis	
<input type="checkbox"/> Edema	<input type="checkbox"/> Neuritis/Neuralgia	

FAMILY Medical History Please indicate if **YOUR FAMILY** has a history of the following:
 (ONLY include parents, grandparents, siblings, and children)

<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Incontinence
<input type="checkbox"/> Anemia	<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Asthma	<input type="checkbox"/> Migraines
<input type="checkbox"/> Blood Clots/DVT	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Parkinson's
<input type="checkbox"/> COPD	<input type="checkbox"/> Seizures/Convulsions
<input type="checkbox"/> Depression	<input type="checkbox"/> Stroke
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid Disorders
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Family History Unknown
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> None of the above
<input type="checkbox"/> High Cholesterol	



Welcome! Thank you for selecting 307 Physical Therapy. It is our goal to provide your physical therapy needs as thoroughly and efficiently as possible. To do that, we need to work with you as a team.

As part of the team you need to know and understand a few things. Before we begin we will discuss and explain our treatment plan. Depending on your progress, the plan may need to be changed. An estimate of the total fee for your treatment is virtually impossible because we cannot tell how long it will take you to progress. We will be able to tell you how much each treatment costs. If you are uncertain of any change or cost feel free to ask. We are more than happy to answer your question. Your physician will then be contacted for permission to treat a new diagnosis.

Our policy regarding payment for our professional services is as follows:

- A:** Cash, check or major credit card will be accepted at the time of treatment. Any account not paid in full 90 days after treatment will bear interest at the rate of 1.5% per month or 18% per annum.
- B:** All credit/debit card transactions will be subject to a 3% processing fee.
- C:** Treatment involving any braces, orthotics or soft goods may require a percentage of the total fee be paid before treatment begins or the item is ordered. This is necessary to cover the cost of the device we must pay in advance.
- D:** In the event we have to use an attorney to collect any unpaid balance due for services to you or your family, by signing the information form upon your first visit, you agree to pay all costs of collection, including all attorney fees whether suit is filed or not.

INSURANCE: As a courtesy to our patients, we will file your primary insurance and secondary insurance. Please check your insurance policy prior to service to be sure Physical therapy/Occupational Therapy is covered.

MEDICARE:

307 Physical Therapy accepts Medicare assignment; Medicare payment will be made directly to the provider. The provider agrees to accept the Medicare approved amount as full payment for covered services. The beneficiary may be billed for the 20% coinsurance, any unmet deductible, and for services not covered by Medicare. Medicare Part B helps pay for medically necessary outpatient physical and occupational therapy services. There are limits on these services. A doctor’s referral is required every 30 days.
-Softgoods or Durable Medical Equipment are not a covered benefit (ie, knee brace, orthotics, back brace).

MEDICAID:

There is a 20 visit limit for all Medicaid patients. Softgoods or Durable Medical Equipment are not a covered benefit (ie, knee brace, orthotics, back brace).

WORKERS’ COMPENSATION:

We will process Workers’ Compensation; however, you are required to let us know that you have a workers’ compensation claim and you must provide us with your case number, date of injury, social security number, and employer’s address. If we do not receive a case number from you or if your claim is denied, you will be responsible for all charges incurred. If your case is under objection, you will receive a bill from us until your case is resolved. You must be in constant contact with your caseworker. If there is new information, please let us know.

CAR INSURANCE:

Stay in contact with your claims adjuster. If there is new information, please let us know.

AUTHORIZATION AND/OR REFERRAL REQUIRED

***REFERRAL IS REQUIRED FOR ALL INSURANCES, UNLESS STATED DIFFERENTLY IN YOUR POLICY. IF IT IS WORKERS’ COMPENSATION AUTHORIZATION IS REQUIRED.**

We, at 307 Physical Therapy, strive to help you with all your insurance questions or concerns. As a reminder, any benefits quoted are not a guarantee of benefits. By signing this form, you understand that you are responsible for all accrued charges during your treatment at 307 Physical Therapy.

Patient Signature: _____ Date: _____

Office Staff Signature: _____ Date: _____

MEDICARE ONE TIME AUTHORIZATION:



I _____, request that payment of authorized Medicare benefits be made to 307 Physical Therapy on my behalf for any services, physical/occupational therapy or softgoods, furnished to me by 307 Physical Therapy. I authorize 307 Physical Therapy to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services. If “other health insurance” is indicated in item 9 of the HCFA-1500 in the form of, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, 307 Physical Therapy agrees to accept the charge determination of the Medicare carrier as the full coverage. The patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the character determination of the Medicare carrier.

Beneficiary Signature

Date

ASSIGNMENT AND RELEASE OF INSURANCE BENEFITS: *for ALL insurance, including Medicare supplement/secondary***

I, the undersigned certify that my dependent or I have insurance coverage with, _____

and assign directly to 307 Physical Therapy all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize that 307 Physical Therapy can release all information necessary to secure the payment of benefits. I further authorize 307 Physical Therapy to contact the Insurance Commissioner on my behalf in the event of insurance problems. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date

Please read the below and sign:

- I have read and agree to the above terms.
- I hereby acknowledge receipt of a copy of this form.
- I hereby authorize 307 Physical Therapy to perform such treatments the physician has ordered.
- I understand that 307 Physical Therapy will hold all information regarding my condition confidential.
- I hereby give permission to release necessary information to my insurance company, attorney, medical doctor, Medicare, Medicaid OR Worker’s Compensation.

Name of Patient (Print)

& Signature of RESPONSIBLE PARTY

307 PHYSICAL THERAPY

STANDING AUTHORIZATION FOR RELEASE OF INFORMATION TO SPECIFIC PERSON(S)

May we reach you or the below mentioned persons by phone? _____

I authorize 307 Physical Therapy to share information regarding my treatment, or payment for treatment, with the following individuals:

My spouse or partner (name) _____

My son or daughter (name) _____

Other individual (name) _____

None

ACKNOWLEDGEMENT

I understand that any information disclosed by this authorization may be subject to disclosure by the recipient and will no longer be protected by HIPAA. The Facility and all personnel covered under this entity are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

EXPIRATION

I understand that I may revoke this authorization by submitting a written notice to 307 Physical Therapy. This notice will remain in effect until such time it is revoked.

PATIENT SIGNATURE: _____ DATE: _____

REPRESENTATIVE'S SIGNATURE: _____ DATE: _____

RELATIONSHIP TO PATIENT IF NOT NAMED ABOVE: _____



HIPAA NOTICE OF PRIVACY PRACTICES
307 Physical Therapy

Effective Date: July 03, 2018

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION
PLEASE REVIEW IT CAREFULLY**

WHO WILL FOLLOW THIS NOTICE:

307 Physical Therapy

OUR PLEDGE REGARDING HEALTH INFORMATION:

We are required by law to make sure that health information that identifies you is kept private; to give you this notice of our legal duties/privacy practices with respect to health information about you; and to follow the term of the notice that is currently in effect.

HOW WE USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose health information. Not every use of disclosure in a category will be listed. However, all of the ways are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other personnel who are involved in taking care of you. They may work at our offices, at a doctor's office or other health care providers to whom we may refer you. For example, we may contact your physician's office and speak with a nurse regarding any concern we may have about unusual swelling associated with your ankle rehabilitation.

For Payment: We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about your visit so your health plan will pay us to reimburse you for your treatment.

For Health Care Operations: We may use and disclose health information about you for operations of our facility. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you and documenting that care.

As Required By Law: We will disclose health information about you when required by federal, state, or local law.

Military or Veterans: If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities of the Department of Veterans Affairs as may be applicable.

Workers' Compensation: We may release health information about you for Workers' Compensation or other similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose health information about you for public health activities. These activities generally include but are not restricted to reporting reactions to medications or problems with products and notifying people of recalls of products they may be using.

Health Oversight Activities: We may disclose health information about you to a health oversight agency for activities authorized by law. These oversight activities include, audits, investigations, and licensure.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a court order, 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.

Law Enforcement: We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons, or similar process.

Coroners and Health Examiners: We may release health information to a coroner or health examiner.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to a correctional institution or law enforcement official.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU:

You have the following rights regarding health information we maintain about you.

Right to Inspect and Copy: You have the right to inspect and copy the protected health information that we maintain. Usually this includes health and billing records. You must submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies and services associated with your request. Your request will generally be approved unless there are legal or medical reasons to deny the request. If you are denied access to health information, you may request that the denial be reviewed.

Right to Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment form please contact the Privacy Officer in writing and a form will be mailed to you. Completion of the form must either be legibly handwritten or typed and returned to the Privacy Officer. You must provide a reason that supports your request for an amendment. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition,

we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available;
- is not part of the health information kept by us or for our practice;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Any amendment that we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting Disclosure: You have the right to request a list of accounting for any disclosure of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described. To request this List of Disclosure, you must submit your request in writing to the Privacy Officer. Your request must state a time period which may not be longer than six years and may not include dates before July 03, 2018. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will not notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures within 30 days of your request.

Right to Request Restriction: You have the right to request a restriction of limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment of your care, such as a family member or friend. For example, you could ask that we not disclose information to your spouse about treatments. *We are required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you.*

If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request, in writing, to the Privacy Officer.

Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at home or by mail to a post office box. To request confidential communications, you must make your request, in writing, to the Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. This notice will contain, on the first page, in the top right corner, the effective date. In addition, each time you register for treatment, we will offer you a copy of the current notice in effect if our records indicate you have not been provided with the revised or changed notice.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with us. To file a complaint, contact the Privacy Officer. All complaints must be submitted in writing. *You will not be penalized for filing a complaint.*

Contact Information:

The name and address of the person you can contact for further information or to request any forms concerning our privacy practices is:

Jennifer Mandros, DPT, OCS
2665 E. 2nd St.
Casper, WY 82609
307-337-1740

Effective Date: This notice is effective on or after July 03, 2018

Acknowledgment of Receipt of this Notice:

We will request that you sign a separate notice acknowledging you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name and date that the notice was provided for you. This acknowledgement will be filed with your records.

Please sign the following acknowledgement of receipt of HIPAA Privacy Practices.

I, _____ received or was offered a copy of the Notice of Privacy Practices from 307 Physical Therapy or a designated affiliate.

This acknowledgement will be filed with your records.

Signature

Date