La Plata Physical Therapy Inc.

Patient Information Form

Patient Information

Last Name ______ First Name ______ MI ___ SSN ______

Address ______

Address2 ______ City ______ State MD Zip ______

Home Phone ______ Work Phone ( ) - ______ Cell Phone ______

Date of Birth ______ Gender ______ Marital Status ______ Email ______

Emergency Contact

Last Name ______ Relationship **Spouse**

First Name ______ Phone ______

Employer

Name ______ Phone ( ) - ______

Address ______

Address2 ______ City ______ State ______ Zip ______

Problem

Problem Description ______ Date of Injury ______ Last Physician Visit / /

Referred By ______ Primary Care Physician ______

Latest Referral Information ______ Motor Vehicle Accident **No**

Latest Plan of Care ______ That occurred in: ______

Notes: ______

Primary Insurance

Insurance ______ Deductible ______

ID ______ Max Benefit ______

Group # ______ CoPay ______ CoInsurance ______

Subscriber

Name ______

Relationship ______

Date of Birth ______

Secondary Insurance

Insurance ______ Deductible ______

ID ______ Max Benefit ______

Group # ______ CoPay ______ CoInsurance ______

Subscriber

Name ______

Relationship ______

Date of Birth ______

Tertiary Insurance

Insurance ______ Deductible ______

ID ______ Max Benefit ______

Group # ______ CoPay ______ CoInsurance ______

Subscriber

Name ______

Relationship ______

Date of Birth ______

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the Patient Registration form.

I understand that I will be charged $25 for all no-shows/cancellations w/out 24 hour notice.

I hereby acknowledge that I have read and reviewed a copy of the Notice of Privacy Practices and the clinics Medical Authorization form.

Signature: ______ Date: ______

LA PLATA PHYSICAL THERAPY
AND YOUR HEALTH INFORMATION

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 IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 19196 (HIPAA) is a federal program that required that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you the patient, significant new rights to understand and control how your health information is uses. HIPAA provides penalties for covered entities that misuse personal health information.
The Practice (La Plata Physical Therapy) in accordance with the federal Privacy Rule, 45 CFR parts 160 and 164 (the Privacy Rule) and applicable state law, is committed to maintaining the privacy of your protected health information (PHI).
PHI includes information about your health condition and the care and treatment you receive from the practice and is often referred to as your health care or medical record. This notice explains how your PHI may be used and disclosed to third parties. This notice details your rights regarding your PHI.

USES AND DISCLOSURES

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing, or collection activities, and utilization review. An example would be sending a bill to your insurance company for payment.

Health Care Operations
include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

Other uses and disclosures of health information

We may create and distribute de-identified health information by removing all references to individually identifiable information.

Unless you provide us with alternative instructions, we may contact you to provide appointment reminders or requesting changes to appointment times, for example, inclement weather conditions making it unsafe to travel. We also may contact you to provide information about treatment alternatives for other health related benefits, programs, or services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your PHI, which you can exercise by presenting a written request to the privacy officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of ______________________________, 20__ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy practices have been violated. You have the right to file a written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against your for filing a complaint.

Please contact us for more information.

For more information about HIPAA
or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, DC 20201
202.619.0257
Toll Free: 1.877.696.6775

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practice containing a more complete description of the uses and disclosers of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restriction, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patients Name (Print) ____

Signature: ____

Relationship to Patient: ____

Date: ____

La Plata Physical Therapy, Inc. 101 Centennial Street, Suite C, La Plata, MD 20646

MEDICAL AUTHORIZATION

1. I authorize the release of any medical information required in the processing of applications for financial coverage for services rendered on this date and all subsequent dates while under the care of La Plata Physical Therapy.

2. I have authorized direct payment of medical benefits on my behalf to La Plata Physical Therapy. I understand that I am personally responsible for charges not covered by this assignment at the time of treatment, such as copay and deductible charges. This assignment shall be in effect for this date and all subsequent dates while under the care of La Plata Physical Therapy.

3. **Copays and payments** are due at the time of service.

4. If your insurance is a plan with a coinsurance, we will collect payment as follows:

5%-10% coinsurance = $15.00 payment each visit
15%-20% coinsurance = $20.00 payment each visit
25%-30% coinsurance = $25.00 payment each visit
40% or more coinsurance = $30.00 payment each visit.

5. I understand that due to the rising costs of insurance deductibles**, I may be asked to make advanced payment toward my deductible at the time of service**. I understand that if I refuse I am then responsible for full payment once all services are complete.

6. I understand that it is my responsibility to present a written referral from my primary care doctor if required. If my insurance company denies my claim because I did not bring in a referral from my PCP, I fully accept the responsibility of paying the charges I have incurred at each visit.

7. La Plata Physical Therapy does not accept payment through any attorney.

8. La Plata Physical Therapy **accepts accident cases** of any nature or cause including, but not limited to, auto, boat, falls, or other types of accidents on a **SELF-PAY BASIS ONLY.** The patient will be required to submit claims and documentation to their own insurance and/or attorney.

9. I understand that there is a **$25.00** charge for **ANY** appointments that are cancelled or broken without 24 hours notice.

10. I also understand that I am responsible for any collection fees incurred if my account becomes delinquent.

Signature: ____

Date: ______________________

PRESCRIPTION & NON-PRESCRIPTION MEDICATION FORM

Name________________________

DATE	NAME OF MEDICATION	HOW MUCH DO I TAKE	ROUTE (Oral, Injectable, Topical or Other)	HOW OFTEN DO I TAKE IT	WHAT DO I USE IT FOR?	**CHANGES OFFICE USE ONLY**