Park South Physical Therapy, P.C.

PARK SOUTH PHYSICAL THERAPY P.C.

Personal Information

Name: _____ Date: _____

Sex: ( ) Male ( ) Female Date of Birth: ____ /____ /____ Age: _____

Phone: _____ SS #: _____ Driver's License#: _____

Have you been a patient here before? _____

Mailing Address: _____
City State Zip

Employer: _____ Employer Phone #: _____

Employer Address (city): _____

Notify In Case of Emergency: _____ Phone #: _____
(Name) (Relationship)

Diagnosis/Chief complaint: _____ Is this a work related injury? _____

Date of Onset (when problem first appeared): _____ Referring Physician: _____

Family Doctor: _____ Are you receiving ANY home health services? _____

Insurance Information

Insurance Company: _____ Contract #: _____

Insurance Policy Holder Name: _____

Secondary Insurance Company: _____ Contract #: _____

Person responsible for payment (if not patient):

Name: _____ Relationship to patient: _____

Address: _____ Driver's License #: _____
City State Zip

Phone #: _____ SS #: _____

Place of Employment: _____ Phone #: _____

How did you hear about our office? ( ) Former patient ( ) Family Member ( ) Doctor ( ) Friend ( ) Other

_____
Patient/Responsible Party Signature Date

Revised February 2013

PARK SOUTH PHYSICAL THERAPY P.C.

Financial and Payment Information

As a courtesy to you, we will bill your insurance company for the treatment you receive at this office. You must realize, however, that you are ultimately responsible for the bill and that your insurance is a contract between you and the insurance company. Please note that not all services are a "covered benefit" in all contracts, and your insurance company may not tell us this information until after you have received the treatment.

Physical therapy is considered a MAJOR MEDICAL, so if you have not met your deductible you will have to pay for all of the treatments until your major medical deductible is met. We ask that you pay at each visit until you reach your deductible.

After your deductible is met, most insurance will pay a certain percentage of the allowable charges (and our charges are considered reasonable and allowable); however, it varies with each insurance contract.

We will call your insurance company and find out as much as we can about what the deductible is on your particular contract. We will also find out what percent your insurance will pay toward Physical Therapy charges.

You can either pay your percent at each visit, or you can wait until the end of the week and pay one time per week. We accept MasterCard and VISA. You will continue to receive statements until your bill is paid in full. Supplies such as pulley sets, exercise band and exercise tube, back supports, ice packs, etc. may not be covered by your insurance and you will be responsible for paying for these items.

We want to help you and will work with you any way we can. If payment will be a problem, please speak with our staff in the front office. If you have ANY questions about your account or statement, please contact our office at 256-378-3390.

_____

Initials and Date

Revised February 2013

PARK SOUTH PHYSICAL THERAPY

AGREEMENT TO PAY

I understand and agree that I am personally responsible and liable for all payments of all charges assessed for professional services rendered. I understand that insurance claim forms will be submitted to my insurance company as a matter of convenience only and that I am primarily responsible for all charges regardless of my existing medical coverage. In the event my insurance company forwards payments directly to me, I will deliver such payments to Park South Physical Therapy, P.C.

I understand that in the event I do not fulfill my financial obligation to Park South Physical Therapy, P.C., my account, including information I have provided in these registration materials, could be turned over to a collection agency or attorney for collection of my unpaid balance.

DATE PATIENT OR LEGAL GUARDIAN

INSURANCE AUTHORIZATION

I hereby authorize Park South Physical Therapy, P.C. to release any and all information necessary, in order to submit my insurance claims to my insurance companies. I understand that my insurance may be billed electronically, through approved and secure transmissions. I request that my insurance company pay benefits directly to Park South Physical Therapy, P.C. for services rendered. I also understand that I am responsible for any unpaid balance to Park South Physical Therapy, P.C.

DATE PATIENT OR LEGAL GUARDIAN

PATIENT BILL OF RIGHTS

I have received a copy of the "Patient Bill of Rights" and understand that it is my responsibility to read this document and ask questions if I do not understand.

DATE PATIENT OR LEGAL GUARDIAN

PARK SOUTH PHYSICAL THERAPY, P.C.

CONSENT AGREEMENT

I understand that my present condition is such that physical therapy treatment is indicated. Consent is given to PARK SOUTH PHYSICAL THERAPY for evaluation and appropriate physical therapy treatments that is directed by my physician and/or assistant named by him/her. I have read this consent for treatment in its entirety and I understand its meaning. I also certify that no guarantee or assurance has been made as to the results that may be obtained.

_____ _____

Date Patient or Legal Guardian

Consent is given to PARK SOUTH PHYSICAL THERAPY for appropriate discussion of patient status, treatment and plan of care with attending physician, physician's assigned nurse, rehab nurse/case manager, employers medical representative or human relations personnel, vocational rehab specialist, attending family member or school official (principal or coach)

_____ _____

Date Patient or Legal Guardian

The undersigned does hereby authorize PARK SOUTH PHYSICAL THERAPY to obtain medical information relating to my medical condition for which I have been referred for physical therapy treatments. The undersigned also authorizes PARK SOUTH PHYSICAL THERAPY to release appropriate medical information to my physician, rehab nurse, case manager, insurance payors and/or employer medical representative, as needed.

_____ _____

Date Patient or Legal Guardian

Notice of Privacy Practices

The Privacy Policy of Park South Physical Therapy, P.C. is simple and direct: We respect your privacy, and we are committed to protecting it. This Privacy Statement describes how we handle your personal and "Protected Health Information."

During the registration process, you gave written consent for Park South PT to use your information in different ways, such as filing insurance claims and communicating with your physician. We limit how, and with whom, we share your information.

For electronic claim processing, we use HIPAA compliant software by Blue Cross. For paper claims, we provide only the information necessary to process the claim.

Our Business Office is a protected area, not utilized by visitors or patients. Copies or duplicates of any document with patient information, such as date of birth or address, are shredded. Day sheets, superbills and other patient data are maintained in a filing cabinet in the business office. Patient Sign In sheets are individual stickers, removed after the patient sign-in, and placed in a protected area.

Your medical record is considered "Confidential" and is not left open or accessible for others to view. Patients and their family and friends are not allowed to sit at therapist work desk in the gym. We restrict access to your chart to only those employees who need it to do their job.

We maintain physical and procedural safeguards to protect the security of your personal and Protected Health Information.

We do not disclose any personal information or Protected Health Information to third parties unless we have your written permission or as permitted by applicable law. Employees with access to your chart are required to strictly maintain the confidentiality of ALL patient information.

Duncan Crowder is the person in charge of Privacy Issues. You can write to him or call him at the Park South office.

This Privacy Policy may be modified to comply with applicable laws or to conform to our current business practices, without prior notice to you.

I acknowledge that I have received a copy of this Privacy Notice and that it is my responsibility to ask questions if I do not understand it.

_____ _____

Patient (or Legal Guardian) Date

Patient Rights

1. **Access to Care:** You have the right to receive treatment at our facility, that is within our capacity to deliver, regardless or race, creed, sex, national origin, religion, disability, or source of payment for care.

2. **Respect and Dignity:** You have the right to considerate and respectful care, with recognition of your personal dignity and spiritual and cultural variables that influence your perception of your illness.

3. **Privacy and Confidentiality:** You have the right, within the law, to personal and informational privacy.

   You have the right not to speak with anyone who is not officially connected with this office.
   You have the right to wear personal clothing and religious or other symbolic items, as long as they do not interfere with your treatment.
   You have the right to be evaluated in private surroundings. This includes the right to have a person of one's own gender present during certain parts of the evaluation, treatment, and/or procedure when performed by a therapist of the opposite sex.
   You have the right to expect that any discussion of anything relating to your care at Park South will be discreet and handled in a confidential manner.
   You have the right to examine your record and have the contents explained to you, except when restricted by law.
   You have the right to know that your records will be read only by those who are directly involved in your care, and by other individuals, only on your written authorization.

4. **Personal Safety:** You have the right to expect reasonable safety insofar as the facility practice and environment is concerned.

5. **Identity:** You have the right to know the name and professional background of the people who provide treatment to you.

6. **Information:** You have the right to obtain information from your therapist relating to your diagnosis and treatment.

7. **Consent:** You have the right to the information necessary to enable you, in collaboration with the therapist, to make treatment decisions involving your health care that reflect your wishes.

8. **Refusal:** You have the right to refuse any treatment. You have the right to request your treatment be transferred to another therapist within this office whenever there is another therapist on site. You also have the right to cancel therapy at this office and have your therapy transferred to another facility.

9. **Itemized Statement:** You have the right to request and receive an itemized statement for the services you received at this office. You have the right to have someone explain the statement to you in a private and confidential manner.

10. **Patient Complaint:** You have the right to voice a complaint, either written or verbal, to any staff member of this office, and to expect a prompt response, by the owner of the practice, to your complaint. You also have the right to expect no recrimination for the complaint you offer.

Name: _____ Date: _____