Orthopedic & Sports Physical Therapy

Patient Understanding of Office Policies

Thank you for choosing Orthopedic & Sports Physical Therapy for your physical therapy needs.

1. A $25.00 charge will be applied for all missed appointments.
2. A $25.00 charge will be applied for all appointments canceled without a 24 hour notice.
3. If you are 15 minutes late for your scheduled appointment, you may be asked to reschedule.
4. If you no show for your appointments 2 times, you will be discharged from our practice.
5. Only the patient is allowed in the treatment area, unless the patient is a child. This is for safety reasons.
6. No cellular phone usage while you are in the treatment area
7. Copays and payments are due at the time of service.
8. If you are a patient with a coinsurance (%) that you are responsible for, we will collect payment as follows:

   5%- 10% coinsurance = $10.00 payment every visit

   15%-20% coinsurance = $15.00 payment every visit

   25%-30% coinsurance = $20.00 payment every visit

   40%-60% coinsurance = $25.00 payment every visit

   This will help to cut down on your final bill. You will receive a monthly bill if you have a balance on your account. Keep in mind if you have a deductible, the payment we collect may not cover your entire coinsurance amount. Please check your explanation of benefits that your insurance company will mail to you for your reference.
9. Should your account become delinquent and be forwarded to an outside collection agency you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorney's fees, we incur in such collections efforts.

If you have any questions regarding our office policies please feel free to ask.

______________________	______________________	__________
Print Name of patient	Signature of patient	Date

If patient is a minor: please provide information on the person filling out the paperwork below:

______________________	______________________	__________
Print Name	Signature	Date

Relationship to patient: ______________________

Orthopedic & Sports Physical Therapy

NOTICE OF PRIVACY PRACTICES

Our Legal Duty: We are required by applicable federal law, including the Health Insurance Portability and Accountability Act (HIPAA), to maintain the privacy of your health information. We must follow the privacy practices that are described in this notice while it is in effect. This Notice took effect on March 14, 2014 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and terms of this Notice at any time, provided such changes are permitted by applicable law. The new terms of our Notice will be effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make significant changes to our privacy practices, we will change this Notice and make the new Notice available upon request.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payments and healthcare operations. For example:

- Treatment: We may use and disclose your health information to a physician or other healthcare provider providing treatment to you.
- Payment: We may use and disclose your health information to obtain payment for services we provide to you.
- Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
- When Required by Law: we may use and disclose your health information when we are required to do so by law.

In addition to the disclosures allowed by this policy,

☐ I authorize my health records and information to be shared with the following person(s):

Please print names: ____

☐ I do not authorize my health records or information to be shared with any person other than myself.

By signing below I acknowledge that I have received the Orthopedic & Sports Physical Therapy Notice of privacy practices, that I have read the Notice and that I consent to its terms and conditions.

______________________________	______________________________	______________
Print Name of patient	Signature of patient	Date
______________________________	______________________________	______________
Parent/ Guardian Print Name	Signature	Date

Relationship to patient: ___________________________

Orthopedic & Sports Physical Therapy

Registration Form

Patient Information

Date:

Patient's Name	Date of Birth	Age	Sex ☐ M ☐ F	Martial Status
Home Address Street Apt No.	City		State	Zip Code

Home Number	Cell Number	E-mail address
Social Security No.	Driver License No.	Occupation
Employer	Address	Work No. Ext
Spouse/Parent's Name	Address	Home Phone No
Spouse/Parent's Employer	Address	Work Phone No

Occupation	Social Security No	Driver License No	State

Emergency Contact	Relationship	Phone No

Primary Insurance Information

Please give Your Insurance Card to the Receptionist

Insurance Company	Subscriber's Name	DOB
I.D. No	Group No	☐ HMO ☐ PPO
Patients relationship to subscriber ___ Self ___Child ___Spouse ___Other	Employer	Co-payment $

Secondary Insurance Information

Insurance Company	Subscriber's Name	DOB
I.D. No	Group No	☐ HMO ☐ PPO
Patients relationship to subscriber ___Self ____Child ___Spouse ___Other	Employer	Co-payment $

Referral Information

Who referred you to our office?	Do you have a referral? ☐ Yes ☐ No

Primary Care Doctor's Name	Address	Phone No	Fax No