SOUTH COUNTY PHYSICAL THERAPY AND REHABILITATION CENTER, INC.

6767 9th Avenue
Port Arthur, TX 77642
Ph: (409) 985-9365 • Fax (409) 985-6315

I consent to treatment and I authorize payment of medical benefits to South County Physical Therapy and Rehabilitation Center, Inc. for medical services rendered.

X_____ Date:_____

Patient signature or guardian for the minor patient

South County Physical Therapy Inc.

6767 9th Avenue Port Arthur, TX 77642
Ph: (409) 985-9365 • Fax (409) 985-6315

Patient's Name_____ _____ _____
Last First M.I.

SS#_____ **Date of Birth**_____/_____/_____ **Sex**: M/F **Marital Status**_____

Home Address_____ **Apt #**_____

_____ _____ _____
City State Zip Code

Home Phone Number:_____ **Work**_____ **Cell**_____

Email Address_____

Referring Physician_____

Insurance Company_____ **Policy Number**_____

Name on Insurance Card_____ **Relation to Patient**_____

Date of injury if it applies____/____/____ **State in which the accident occurred**_____

Injury is: ☐Work Related ☐Car Accident ☐Other (describe)_____

_____

Name of Emergency Contact:_____**Phone**_____

Relationship_____

I, the undersigned have agreed to provide South County Physical Therapy with the necessary referral and documents to bill my insurance plan or other responsible party. If I elect to be seen without a referral, I agree to accept financial responsibility for all charges incurred. I understand and agree to be responsible for all co-pays, and balance not covered by my insurance plan. All therapy is intended to benefit our patients; however, there are risks associated with any exercise program or procedure. By signing below, you understand and accept all risks associated with treatment at our facility.

X_____ **Date**_____

PATIENT HISTORY / PAIN SYMPTOMS

1. **Where is the pain located now?** _____
   _____

2. **Do you have any numbness, tingling, or different sensations? If so, where?** _____
   _____

3. **Do any of the following intensify your symptoms?** (Circle all that apply)
   ☐Coughing ☐Sneezing ☐Sitting ☐Standing
   ☐Turning ☐Changing Positions ☐Lifting ☐Bending
   ☐Increased Activity ☐Driving

4. **Have the symptoms changed since onset?** (check) ☐Same ☐Increased ☐Decreased

5. **When is the pain <u>MOST</u> severe?** ☐Morning ☐Afternoon ☐Night
   <u>LEAST</u> severe? ☐Morning ☐Afternoon ☐Night

6. **Are headaches a problem?** ☐YES ☐NO

7. **Have you experienced any loss of strength?** ☐YES ☐NO

8. **What type of mattress do you sleep on?** ☐Water Bed ☐Firm ☐Soft ☐Adjustable

9. **Is your sleep interrupted by pain?** ☐YES ☐NO

10. **Is there any position that makes you more comfortable or pain free?** _____
    _____

11. **Please list ANY medications you are currently taking**: _____
    _____

12. **Do you have a past medical history of the current problem? Including previous surgeries, fractures, etc.?** _____

13. **Do you have any important information to share with us? (Pacemaker, pregnancy, etc.)**
    _____

14. **Have you received physical therapy in the past?** ☐ YES ☐ NO

15. **How is your overall health?** _____

16. **Are you currently employed?** ☐ YES ☐ NO
Are you working at the present time? ☐ YES ☐ NO
What is your occupation? _____

17. **Are you receiving any treatment at home?** (Heating pad, ice, home exercise, etc.)
_____

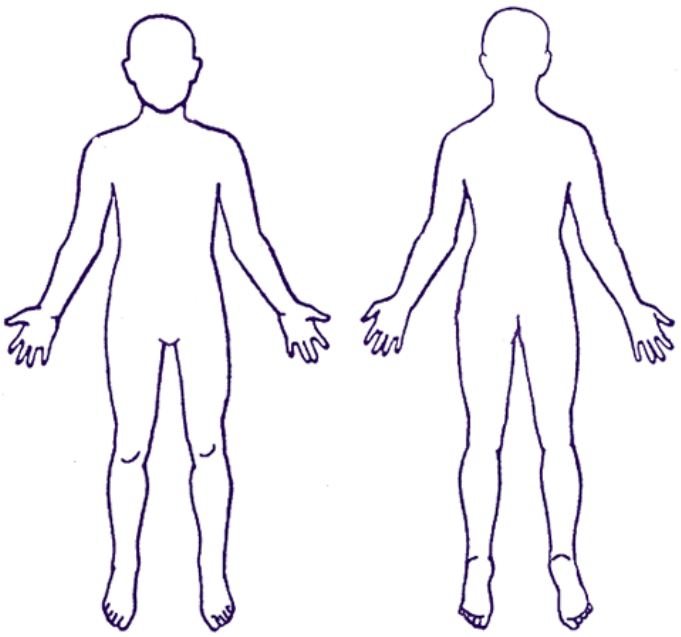
18. **Are you receiving any other treatment for this condition?** (Chiropractic, acupuncture, etc.) _____

19. **What special tests have you had?** (X-rays, CAT Scan, MRI, EMG, etc.) _____
_____

20. **Does your pain/symptoms interfere with your functioning or activities of daily living?**
☐ YES ☐ NO

21. **Any other pertinent information?** _____
_____
_____
_____
_____

On the model below, please mark the areas of the pain you are having:



FRONT **BACK**

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDIAL 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 1996 (HIPPA) is a federal program that requires 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 proper confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.
We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordination, 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 of this would be sending a bill for your visit 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 client services. An example would be an Internal Quality Assessment Review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may use or disclose protected health information to carry treatment, payment, or health care operations in the following circumstances:

- In emergency situations.
- If we are required by law to treat you; or
- We may contact you to provide appointment reminders or information about treatment alternatives or health-related benefits and services that may interest 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 authorization, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

- The right to request restrictions on certain uses and disclosures or protected health information, including those related to disclosures to family members, other relatives, close 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 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 April 14, 2003 and we are required to abide by the terms of the Notice Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices 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 your privacy has been violated.** You have the right to file a formal, written complaint with us at the address below, 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 you, for filing a complaint.

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____

Signature of Patient or Patient's Representative Date

_____

Print Name of Patient or Patient's Representative

_____

Description of Patient's Representative Authority

For more information about HIPPA or to file a complaint:
The U.S Department of Health Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Please contact us for more information:
Privacy Office: Tonya Culver
Practice Name: South County Physical Therapy
6767 9th Avenue
Port Arthur, TX 77642
Ph: (409) 985-9365 Fax (409) 985-6315

IF YOU ARE RECEIVING ANY TYPE OF CARE (vital signs, etc.) FROM A HOME HEALTH AGENCY PLEASE INFORM US SO WE CAN BILL YOUR INSURANCE PROPERLY. IF YOU FAIL TO INFORM US AND YOUR INSURANCE DENIES YOUR CLAIM YOU WILL BE RESPONSIBLE FOR THE ENTIRE BALANCE.

Date:_____ Patient Signature_____

SOUTH COUNTY PHYSICAL THERAPY AND REHABILITATION CENTER

Mark Culver, P.T.
Director of Physical Therapy

6767 9th Avenue
Port Arthur, TX 77642

Phone: (409) 985-9365 Fax (409) 985-6315

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our professional free with you any time. Your clear understanding of our Financial Policy is important to our professional relationship.

- FULL PAYMENT IS DUE AT THE TIME OF SERVICE.
- WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND CARE CREDIT.

INSURANCE: We will file your insurance claim as a courtesy to you. However, if we do not receive payment from your insurance company within 45 days of filing, you will be required to make payment in full. Your insurance policy is a contact between you and your insurance company. If your insurance policy/company should change during treatment, it is your responsibility to notify our staff. We cannot bill without ALL current information. YOU are solely responsible for your account.

FINANCE CHARGES: Finance charges will be applied to all accounts over 45 days. 15% interest will be added to your balance due.

COLLECTION PROCEDURES: In the event that a collection agency and/or attorney would be needed, you are responsible for all collection/legal fees.

MISSED APPOINTMENTS: I understand that this office reserves the right to charge **$35.00** for appointments not cancelled within 24 hours notice. I also understand that I will be considered a new patient if I have not been seen in the last three years and will be subject to new patient office policy should I decide to return. **This is standard procedure for all medical offices as directed by the federal government.**

Please help us serve you better by keeping scheduled appointments.
Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

_____

Responsible Party Signature Date

PATIENT BILLING AND COLLECTIONS POLICY FOR PATIENTS WITH INSURANCE

1. Your insurance company or companies will be contacted within 48 hours or your first visit.
    - Your benefits, eligibility, deductible amounts, pre-certification and co-pay information will be gathered from your insurance company specific to your policy.
2. Any co-pay required is collected at the beginning of each visit at the time you sign in for treatment each time.
    - You will be given a receipt for each co-payment and a copy of each payment is placed in your chart.
    - If you are unable to pay the full amount of your co-pay for each visit, talk to the Office Manager to see if you qualify to establish a payment plan for the co-pay amounts due.
3. As a courtesy to our patients, we will file your charges/claims to your insurance company or responsible party on your behalf. However, if your insurance does not cover any part or all of your treatments you will be responsible for your bill, minus any amounts you have already paid. (Ex. $100.00 - $25.00 co-pay = $75.00 due)
    - You will receive a statement from SCPT after your insurance has been billed and paid their portion or in 30 days if insurance has not or will not pay.
    - We will make every attempt within reasonable effort to collect from your insurance company. We will provide additional information as requested by insurance and file up to 2 appeals on your behalf in cases where claims are denied or delayed.
4. If you are bringing in a minor for treatment, you are the responsible party for that bill.
5. You are responsible for supplying us (SCPT) with the most current and accurate insurance information that you have. If ANY PART of your insurance policy or information changes while a patient here at SCPT, you are responsible for notifying the Office Manager and providing the changed information in writing or allowing us to update your file with a new copy of your card.
    - You may be asked periodically if there have been any changes in your insurance information. This is an effort to prevent delays in the insurance companies processing of your claim and to reduce headaches for everyone.
6. Some modalities/treatments used as standard part of physical therapy are not covered by all insurance companies and are considered very beneficial to our patients recovery and comfort. You agree to be responsible for those modalities or supplies.
7. We will do our part to make your treatments as cost effective as possible.
8. Billing statements will be sent out every 30 days.
    - I also understand that should my account be turned over for collections proceedings, I will be responsible for all additional fees incurred in an attempt to resolve my outstanding balance.

WE SINCERELY WANT TO AVOID THIS STEP AND WILL MAKE EVERY ATTEMPT TO WORK WITH OUR PATIENTS TO AVOID THIS COLLECTION STEP.

It is our pleasure to serve you, if we can be of assistance or if you have any questions regarding your bill, please call us at: (409) 985-9365

By signing this document you understand and accept the terms of SCPT Billing and Collections Policy

_____ _____

Patient Signature Date

South County
Physical Therapy
Your Step In the Right Direction
Since 1966

Assignment of Benefits Agreement

Our office will accept assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your physical therapy benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to fill out insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company . This instructs your insurance company to make payment directly to our office.
- We require you to make the co-payment or co-insurance, which is the amount not covered by your insurance company, at the time we provide service to you.
- Insurance payments ordinarily are received within 45 days from the time of billing. If your insurance company has not made payment to our office within 45 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- Our office does not guarantee that your insurance company will pay for the treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our office will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY MEDICAL BENEFITS DIRECTLY TO THE PHYSICAL THERAPIST.

_____ _____

Signature of Patient/Responsible Party Date

SOUTH COUNTY PHYSICAL THERAPY, INC.
6767 9th Ave
Port Arthur, TX 77642
Phone 409-985-9365 Fax 409-985-6315

Pain Disability Index

Name:_____ Date:_____

Pain disability index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much your pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (ex. Yard work) and errands or favors for other family members (ex. Driving the children to school).

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Recreation: This category includes hobbies, sports, and other similar leisure time activities.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Social activity: This category refers to activities that involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Occupation: This category refers to activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a housewife or volunteer worker.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Self care: This category includes activities, which involve personal maintenance and independent daily living (ex. Taking a shower, driving, getting dressed, etc.)

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Life-supporting activity: This category refers to basic life-supporting behaviors such as eating, sleeping, and breathing.

No disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Overall Score:_____

References: 1. Pollard CA. Preliminary validity study of the pain disability index. *Percept Mot Skills*. 1984;59 (3): 974