SPORTS CENTER PHYSICAL THERAPY
CO-PAYMENT, CANCELLATION, AND "NO SHOW" POLICY

Your insurance company may require you to pay a co-payment for physical therapy at the time of service. Many companies list the co-payment amount on the card beside OV (office visit). In some cases, physical therapy will fall under the "Specialist" co-payment listed on the card. In other cases, the co-payment may not be on the card at all, and we won't know the amount until we receive a statement from the insurance company. We encourage you to review your policy before you start physical therapy.

Our Co-Payment Policy is as follows:

1. Co-payments are due at the time of service provided.

2. We accept cash or checks (payable to SCPT). We do not accept credit or debit cards at this time.

3. We do not bill for co-payments. It is the patient's responsibility to stay current with co-payments.

5. Patients under the age of 18 must have a parent or guardian sign this form. It is the parents or guardians responsibility to stay current with co-payments.

6. If benefits become exhausted or unpaid under a Motor Vehicle or Workers Compensation claim, all cumulative co-payments are due immediately as dictated by the patient's private health policy.

Appointment space is often limited in our busy practice. Many patients have an urgent need for physical therapy. It is extremely important to contact our office if you cannot make a scheduled appointment.

Our Cancellation/"No Show" Policy is as follows:

1. We would greatly appreciate 24 hours notice on all appointment cancellations when possible.

2. A $20 fee will be charged to patients who do not show up for a scheduled appointment and fail to contact us before that scheduled appointment time.

I acknowledge receipt of this notice_____ _____
Signature Date

SPORTS CENTER PHYSICAL THERAPY
MEDICAL HISTORY QUESTIONNAIRE

High Blood Pressure? _____ High Cholesterol? _____ Stents? _____

Heart Attack? _____ Coronary Artery Bypass Surgery? _____

Do you have a Cardiologist? _____

Any other cardiac procedures?_____

Asthma or other Respiratory Illness? _____

History of cancer? _____

Diabetes? _____ Type I or II? _____

History of seizures? _____

Any Bleeding disorder? _____

Any significant allergies? _____ Latex allergy?_____

Is there any chance that you are pregnant? _____

Are you a tobacco user? _____ What type(s)? _____

List Orthopedic surgeries: _____
_____
_____

LIst other surgeries: _____
_____
_____

List of medications: _____
_____
_____
_____
_____

Other medical information: _____
_____
_____
_____

SPORTS CENTER PHYSICAL THERAPY
NEW PATIENT INTAKE SHEET

Date: _____ Home Phone: _____ Cell Phone: _____

Patient: _____
last name first name middle initial

Sex: M ____ F ____ Date of Birth: _____ SSN: _____

Mail Address: _____

_____

Email: _____Occupation: _____

Responsible Party (if minor): _____

Referring Physician: _____ Primary Physician: _____

Date of Injury: _____ Work Related? _____ Motor Vehicle Accident? _____

Have you had Physical Therapy this year? _____ How many visits? _____

How did you hear about us? _____ Returning Patient? _____

Primary Insurance Information (complete if you <u>do not</u> have your insurance card):

Name of Subscriber: _____

Name of Insurance: _____ Policy number: _____

Assignment and Release:

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ _____ and assign directly to SCPT all insurance benefits, if any, payable to me for services rendered. I understand that I am responsible for all charges, whether or not paid by insurance. I hereby authorize SCPT to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand that SCPT contracts internships with colleges. I authorize observation and/or treatment by said interns.

_____ _____ _____
Responsible party signature Relationship Date

SPORTS CENTER PHYSICAL THERAPY
NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and shared with others and how you can access your information. It applies to any services you receive from any doctor, nurse, or licensed clinician. We are required by the Health Insurance Privacy & Accountability Act (HIPPAA) to maintain privacy of your Protected Health Information (PHI) and provide you with this notice. Please review it carefully.

In certain situations, we need to obtain your written signature in order to use and share your PHI with others. In other situations we do NOT need your signature to release information. They are as follows:

- To provide treatment and services to you. This includes referrals to specialists and calling regarding appointments.
- To obtain payment from insurers.
- For quality assurance operations or to resolve complaints.
- Disclosures to friends or relatives when your are present or available if we obtain your agreement and you do not object. If you are not present, or the opportunity to agree or object to a use or disclosure cannot reasonably be provided because or your incapacity or an emergency circumstance, we may exercise our judgement or determine whether a disclosure is in your best interest.
- We may disclose your PHI in connection with the following public health activities: (1) to report to public health authorities for the purpose of preventing or controlling disease, injury, or disability; (2) to report child or elder abuse and neglect to public health authorities of other government authorities authorized by law to receive such reports; (3) to report information about products and services that fall under the authority of the FDA; (4) to alert a person who may have been exposed to a highly contagious disease or may otherwise be at risk of contraction or spreading such a disease or condition; and (5) to report information to your employer as required under laws addressing work related injuries and illnesses or workplace medical reporting regulations.
- If we believe or have reason to know that you are or have been a victim of abuse, neglect or domestic violence, we may disclose your PHI to a governmental entity, including a social service or protective service agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.
- We may disclose your PHI in the course of a judicial or administrative proceeding in response to a court order. We may share you PHI with police or other law enforcement officials as required by law or in compliance with a court order.
- We may use or disclose your PHI to prevent or lesson a serious or imminent threat to a person's or the public's health or safety.
- Worker's Compensation. We may share your PHI as authorized by and to the extent necessary to comply with state and/or other laws relating to workers compensation or other similar types of programs.
- Disclosures to Employers. We may disclose your PHI to your employer when we provide a health care service to you at your employers request, either to (1) conduct an evaluation relating to medical surveillance of your workplace, or (2) to evaluate whether you have a work related illness or injury. Under these circumstances, we will only disclose your PHI that consist of our findings concerning your work related illness or injury or the medical surveillance of your work place, and your employer's need in order to comply with its obligations under state and/or federal laws to record work related illnesses or injuries or to conduct medical surveillance of your workplace.
- We may use and disclose you PHI to units of the government with special functions, such as the Coast Guard or the Department of State, under certain circumstances.
- As Required by the Law. We may use and disclose your PHI when required to do so by any other law not already mentioned above.

_____ _____

Signature Date