<u>*NEW PATIENT INFORMATION*</u> Required if last appointment was more than 5 years ago.

Patient's Name _____ Birthdate _____

Social Security Number **<u>or</u>** Driver's License Number _____ State _____ (for patient or guardian)

Emergency Contact _____Relationship _____ Phone# _____

FINANCIAL INFORMATION **IF SELF, PLEASE SKIP.**

Guardian Name _____Relationship _____ Phone # _____

Guardian Address _____

Insurance Holder's Name _____ Birthdate _____ Relation _____

Insurance Holder's Address _____

COMMUNICATION **PLEASE CIRCLE BELOW**

What type of reminders would you like to receive for your upcoming appointments? Text Voice Call Email None

NOTICE OF INFORMATION PRACTICES

You have the right to:

- Request a restriction on certain uses and disclosures of your information (45 CFR 164.522)
- Obtain a paper copy of the notice of information practices upon request
- Inspect and obtain a copy of your health record (45 CFR 164.524)
- Request to amend your health record (45 CFR 164.528)
- Obtain an accounting of disclosures of your health information (45 CFR 164.528)
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

We are required to:

- Maintain privacy of your health information
- Abide by the terms of this notice
- Provide you with a notice as to our legal duties & privacy practices with respect to your information
- Notify you if we are unable to agree to a requested restriction on disclosure or amendment to your record
- Accommodate reasonable requests you may have to communicate health information by alternative means or locations
- We reserve the right to change our practices and to make the changes effective for all protected health information we maintain. If our information practices change, we will notify you at your next appointment.

PATIENT INFORMATION CONSENT (HIPAA)

I have read and understand RPT's Notice of Information Practices. I understand that RPT may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of the service provided, and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations. I also understand that RPT will consider requests for restrictions on a case by case basis, but is not required to oblige to such requests. I consent to the use and disclosure of my personal health information for purposes noted in the above Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying RPT in writing at any time.

Responsible Party Signature _____ Date _____

Relationship to Patient (if other than Self) _____

CURRENT SYMPTOMS

Required for new body part or if last appt was more than 60 days ago.

Patient Name _____ Date of Birth _____

Body Part _____ Symptom First Noticed ____/_____/_____ How did it occur? _____

Did you need surgery? Y N Date of Surgery _____

ACCIDENT INFORMATION

Work Related? Y N Auto Accident? Y N State _____ Date of Accident _____

Do you have an attorney? Y N Name & Phone Number of Attorney _____

PREVIOUS APPOINTMENTS

Have you had Physical Therapy or Home Health **this year**? Y N If yes, how many visits? _____

If you had Home Health this year, have you been formally discharged? Y N Date of Discharge _____

If you are insured by Medicare, do you have a physician's referral for physical therapy? Y N

1. ASSIGNMENT & RELEASE OF INFORMATION

I hereby authorize my insurance company to make payment directly to Registered Physical Therapists Inc (RPT). RPT will make reasonable efforts to collect insurance proceeds. The acceptance of assignment does not relieve the undersigned from the obligation to pay the outstanding balance. I further authorize RPT to release information to my insurance company for claims processing and any other person(s) or company I have listed above. I also permit a copy of this authorization to be used in place of the original.

2.FINANCIAL AGREEMENT

I understand that I am responsible for payment of my account. RPT will file my claims with my insurance company as a courtesy, and will send me a monthly statement of the activity on my account. If collection or legal action is required, I understand that I will be responsible for collection, attorney fees, and court charges if any delinquent balance is placed with an agency for collection or suit. If my account is turned over to a collection agency I will be responsible for an additional 40%. For more details please see our full financial policy (on reverse page) or request to speak to your account manager.

3.MEDICAL & FINANCIAL RELEASE

I understand that I have access to my own medical records until further notice or until written notification is received which requests nullification. **Is there anyone you want to have access to your medical & financial information? (Please list name & relation to you)**_____

I agree to the terms 1, 2 & 3 listed above and agree that the information above is accurate to the best of my knowledge.

Responsible Party Signature _____ Date _____

Relationship to Patient (if other than Self) _____

Please read each section below of our full financial policy.

INSURANCE INFORMATION

We accept most insurance plans and as a courtesy, RPT will submit claims to your health insurance company for you after each visit. You are responsible for all out of pocket expenses (copays, co-insurance and deductibles). We will estimate the co-insurance percentages based on what we expect the insurance company to pay. Because this is an estimate and not an exact figure, there is a possibility that you will still be responsible for an additional balance and/or that you may be due a credit refund if you have overpaid. Your insurance company may contact you for information needed to pay your claims. Please do not ignore the request. Appropriate attention will help avoid delays in processing your claims.

REVIEW YOUR "SCHEDULE OF BENEFITS"

It is your responsibility to know your "Schedule of Benefits" through your insurance plan. You should understand your policy's deductible, copayment, co-insurance, and visit limitations. It will help you understand the agreement you have with your insurance company. You should call your insurance company with any questions regarding your policy/coverage of outpatient physical therapy. As a courtesy, we will also verify your coverage, but we will not guarantee the accuracy of the information we receive. Your insurance policy is a contract between you and your insurance company. You are responsible to know your level of coverage, and you are ultimately responsible for the full payment of your bill.

CHANGES IN COVERAGE

It is your responsibility to inform us of any and all changes of insurance coverage during the course of treatment. Failure to do so may result in denial of coverage by your insurance company. Any outstanding charges will be your responsibility.

SECONDARY INSURANCE & COORDINATION OF BENEFITS

If you have a secondary insurance, we will submit claims to your secondary health insurance company as a courtesy to you. Please be aware that secondary insurance coverage does not guarantee "double coverage". Please be aware that some insurances will not process claims if each insurance plan is unaware of another active policy. You are responsible to inform your insurances of any changes and are responsible for any remaining charges.

MINORS

A parent or legal guardian must accompany the minor patient at the time of the initial visit. The parent or legal guardian that accompanies the minor patient to the clinic will have full responsibility for the payment of the minor's bill as outlined in the above financial policy. Payment is due at the time of the appointment, even if a parent or legal guardian is not in attendance.

PERSONAL INJURY, LIABILITY, AUTO, OR INVOLVEMENT OF AN ATTORNEY

In the event your claims are denied by the liability carrier or that the personal injury protection benefits are exhausted, we will file claims with your personal health insurance policy. You will be responsible for any patient balances that your health insurance deems as patient responsibility upon processing. If your personal insurance policy denies the claim for any reason, you are responsible for the full payment of your bill.
If the claim is related to an automobile accident, I authorize the release of a Personal Injury Protection (PIP) letter and ledger to RPT.

STATEMENTS

Statements are sent out monthly via mail to your address on file. Statements will show any activity on your account including new billing, payments (insurance or patient), adjustments and finance charges, if any. Dates of service paid in full will not appear on future statements. In addition, interest will accrue on all unpaid patient portions after 30 days at the rate of 18% per annum (1.5% per month) until paid in full.

PAYMENT

All patient portion; cash, private pay accounts, copayments, co-insurance and deductibles are due at the time of treatment. We accept cash, check, VISA, MasterCard, Discover card and American Express. A $30.00 service charge will be charged for all returned checks. We will work with you to set-up a customized payment plan if necessary. If you have any concerns, please ask.

COLLECTIONS

We will work with you to avoid sending your account to collections. In the event of default on your account, your account will be referred to a third-party debt collection agency. You will be responsible for the unpaid balance and an additional collection fee of 40% of the principal amount owing as allowed by Utah Code Annotated, sec. 12.1.11. The terms of this paragraph shall apply to all amount(s) incurred by your or by any individual for whom you have legal responsibility. You will be responsible for collection and/or attorney's fees and court costs. If payment arrangements are not kept up on a timely basis, we will proceed to send your balance to our collection agency. After your account is sent to the collection agency, you will be directed to their company to resolve your account. Accounts that are turned over to collections can result in denial of further treatment.

REGISTERED PHYSICAL THERAPISTS, INC.

Advanced, Personalized Care To Get You Back To Work And Play Fast

Electrode Supply Purchase

As part of your physical therapy treatment you may receive a procedure called electrical stimulation. This requires the use of electrodes (small sticky pads) to conduct the electrical current to the area being treated.

For hygiene purposes we suggest that our patients purchase a set of electrodes that will be specifically for your personal use during your treatment. **The charge for this supply is $10.00, which most insurance companies do not cover.** We do not provide the service of billing your insurance for electrodes; therefore, if you opt to receive your own set, you will be charged directly for the supply.

You may opt to use a general electrode set which is free of charge; however, we suggest that each patient have their own set for sanitary reasons.

Please be aware that if you have not been treated for 3 months, we may no longer have your electrodes on file. The electrodes lose their adhesive after that amount of time.

Please mark your preference:

☐ Yes, I request my own set of electrodes ($10 charge)

☐ No, I do not want my own electrodes (Free)

Printed Patient Name _____

Signature _____ Date _____

OFFICE USE ONLY – PLEASE INITIAL

IF PURCHASE IS REQUESTED:

RECEIVED ELECTRODE PAD SET	CHARGE ADDED TO CHART	PAYMENT COLLECTED
☐	☐	☐