



Welcome to THERAPYSOUTH

Insurance Information: As a courtesy to you, we will bill your insurance company. Please provide us with your insurance card and any additional information we may need. We recommend that you call your insurance company to verify your physical therapy coverage if there is any discrepancy between what our office has been informed of and what you thought your benefit coverage was. **It is your responsibility to know your policy benefits and limitations.** Our billing office is available to answer questions you may have regarding our billing procedures.

Payment Options: We accept personal checks, cash, Visa, and MasterCard. **Insurance co-payments are due on each visit.** Any portion of your treatments that are not covered by your insurance becomes your responsibility, and is due within 30 days. Interest may be charged at a rate of 1.5% per month (18% annually) for unpaid balances over thirty days old.

Return Check Fee: A **\$35.00 fee** will be charged to the patient for each incident that a check is returned to us for insufficient funds.

Collection of Accounts: A **\$35.00 fee** will be charged to the patient for any account turned over to collections for non-payment. Payment on account is due in full within 30 days from date of service.

Workers Compensation Claims: We will bill your **open**, approved workers' compensation claim. Please be advised that in the event your claim is denied, you are financially responsible for all charges.

Supplies: Supplies purchased by the patient for use in the home are payable in full at the time the patient receives the supply.

Scheduling: We are happy to reschedule your appointments when a conflict occurs; however, we request a 24-hour notice if at all possible. If you fail to attend your appointments and do not give us 24 hour prior notification, you may be charged a fee of **\$25.00** for the time slot allotted for you.

Non-Discrimination: Admission to our clinic is non-discriminatory for services rendered, regardless of race, color, national origin, disability, or age. All clients who come to our clinic for services are protected against discrimination assured by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

Thank you for allowing us the opportunity to serve you. If you have any questions about the above information or any uncertainty regarding your insurance coverage, please do not hesitate to ask for our assistance.

Patient/Legal Guardian Signature

Date



Notice of Patient Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

TherapySouth LEGAL DUTY

TherapySouth is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are disclosed herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

TherapySouth uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, TherapySouth may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

TherapySouth may also use or disclose your personal health information without prior authorizations for public health purposes, for auditing purposes, and for emergencies. We may provide de-identified information for research studies. We also provide information when required by law.

In any other situation, TherapySouth's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

TherapySouth may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of our clinic. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed you personal health information for reasons other than treatment, payment, or other administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. TherapySouth will consider all such requests on a case-by-case basis, but the company is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that TherapySouth may have violated your privacy rights or if you disagree with any decisions made of regarding access or disclosure of your personal health information, please contact our HIPAA Compliance Office at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on TherapySouth's health information practices, or if you have a complaint, please contact the following office:

**HIPAA Compliance Office
TherapySouth
790 Montgomery Highway, Suite 108
Vestavia Hills, Alabama 35216
205-822-7607 • 205-822-7614 fax**



PATIENT INFORMATION					
LAST NAME	FIRST	MI	D.O.B	S.S.N.	SEX: M / F
HOME ADDRESS	CITY	STATE	ZIP CODE	HOME PHONE ()	
CELL PHONE ()	MARITAL STATUS: SINGLE () MARRIED () OTHER ()				
EMPLOYMENT STATUS: FULL-TIME () PART-TIME () STUDENT () N/A ()	EMPLOYER NAME / SCHOOL NAME			TITLE / POSITION	
WORK ADDRESS	CITY	STATE	ZIP CODE	WORK PHONE ()	
E-MAIL ADDRESS: HAVE YOU BEEN TREATED AT THIS OR ANY OTHER THERAPYSOUTH CLINIC BEFORE? IF YES WHERE?					

REFERRING PHYSICIAN INFORMATION		
LAST NAME	FIRST NAME	PHONE

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION			
LAST NAME	FIRST NAME	MI	
ADDRESS	STATE	ZIP CODE	
HOME PHONE	WORK PHONE		
RELATIONSHIP SPOUSE () PARENT () GUARDIAN () OTHER ()	PARENT OR GUARDIAN E-MAIL ADDRESS		

REASON FOR TODAY'S VISIT				
IS THIS INJURY/ ACCIDENT RELATED TO YOUR.....	JOB	CAR	HOME	OTHER
PLEASE INDICATE THE DATE OF ACCIDENT/ INJURY:	/	/		
DESCRIBE ACCIDENT/INJURY:				
PLEASE INDICATE AREA INJURED:				
INSURANCE ADJUSTER OR CONTACT:			TELEPHONE:	

PRIMARY INSURANCE COMPANY INFORMATION			
PRIMARY INSURANCE COMPANY NAME		SECONDARY	
POLICYHOLDER (if other than patient)	SEX: M / F	D.O.B. (of policyholder)	
S.S.N.(of policyholder)	PHONE NUMBER (of policyholder)	RELATIONSHIP TO PATIENT	
EMPLOYER (of policyholder)			

ASSIGNMENT OF BENEFITS / AUTHORIZATION OF RELEASE MEDICAL INFORMATION / CONSENT TO TREATMENT	
<p>As the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility. I hereby assign all medical benefits to which I am entitled to TherapySouth in the event they file insurance on my behalf. I understand that I am Financially Responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment. I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection agency service fees, Attorneys fee, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 1.5% per month (18% annually) for unpaid balances over thirty days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of TherapySouth as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment except acts of negligence.</p>	
AUTHORIZED SIGNATURE X	TODAY'S DATE / /



HEALTH HISTORY

Please check if you currently have or have had any of the following:

- Heart Condition; Please describe _____
- Pacemaker
- High Blood Pressure
- Mitral Valve Prolapse
- Chest Pain
- Abnormal EKG/Stress Test
- Lung Disease
- Asthma or Shortness of Breath
- Seizures
- Cancer; If yes, location _____
- Stroke
- Diabetes
- Falls/Balance Problems
- Dizziness/Fainting
- Headaches; If yes, how often _____
- Parkinson's
- Neurological Condition
- Recent, unexplained weight loss
- Arthritis
- Pregnancy at this time
- Orthopedic surgery
- Osteoporosis
- Depression
- Smoking
- Other; Please explain _____

Are you taking any of the following medications? (Circle)

Pain Anti-Inflammatory Muscle Relaxer Insulin Nitroglycerin Inhaler

I have read and completed this form:

Signature _____ **Date** _____



PATIENT INFORMATION CONSENT FORM

I have read and fully understand TherapySouth's Notice of Information Practices. I understand that TherapySouth may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the company in writing. I also understand that TherapySouth will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in TherapySouth's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the company in writing at any time.

Patient Name: _____

Patient Signature: _____

Today's Date: _____



**DESIGNATED INDIVIDUALS
AUTHORIZATION FORM**

I hereby authorize one or all of the designated parties listed below to request and receive the release of any Protected Health Information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

AUTHORIZED DESIGNEE:

NAME: _____	RELATIONSHIP: _____
NAME: _____	RELATIONSHIP: _____
NAME: _____	RELATIONSHIP: _____
NAME: _____	RELATIONSHIP: _____
NAME: _____	RELATIONSHIP: _____

Patient Name: _____

Patient Signature: _____

Today's Date: _____