# HAND & ORTHOPEDIC PHYSICAL THERAPY SPECIALISTS

## PATIENT INFORMATION *(Please print clearly)*

Patient's Name: _____

Date of Birth: ____/____/_____ Age: _____ Sex: Male □ Female □ Marital Status: Single □ Married □ Other □

Address: _____Apt#: _____ City: _____State:_____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Employer Name: _____ Full Time □ Part Time □ Retired □ Student □

Spouse's Name: _____ Spouse's Birthdate: ____/____/_____

Spouse's Employer: _____ Spouse's Work Phone: _____

Emergency Contact: (*not living with you*) _____Phone: _____

Referring Physician: _____ How you heard about us: _____

Reason for Visit: _____Onset of Symptoms/Surgery Date: ____ /____ /_____

## MEDICARE PATIENTS

► ***please note that Medicare patients must be referred from a doctor for therapy*** ◄

Have you received Home Health Care of any kind in the past 60 days? Yes □ No □

If yes, please provide the name and phone number of the Home Health Agency _____

_____

## RESPONSIBLE PARTY INFORMATION *(Required if patient is a minor)*

Responsible Party Name: _____

Date of Birth: ____/____/_____ Age: _____ Sex: Male □ Female □ Marital Status: Single □ Married □ Other □

Address: _____Apt#: _____ City: _____State:_____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Employer Name: _____Full Time □ Part Time □ Retired □ Student □

## CONSENT TO TREAMENT OF MINOR CHILD

I _____, am the parent/legal guardian of_____ who is currently a minor, whose date of birth is ___/___/_____. I hereby authorize Hand and Orthopedic Physical Therapy Specialist to provide physical/occupational/speech therapy services as may be considered necessary or appropriate under the circumstances. I further understand that once my child reaches the age of majority, my consent for treatment is no longer required.

Signature of Parent/Legal Guardian: _____ Date: ____/____/_____

Parent of Guardian Emergency: (Home) _____ (Cell) _____

Hand & Orthopedic
Physical Therapy Specialists

**Murray**
**5151 South 900 East #100**
**Murray, UT 84117**
**801.261.3321 Fax 801.261.5942**

**Salt Lake City**
**801.328.8535**

**Draper**
**801.501.8359**

**Bountiful**
**801.298.2533**

# FINANCIAL POLICY

This is an agreement between Hand & Orthopedic Physical Therapy Specialists and the Patient/Responsible Party signed on this form. By executing this agreement, you are responsible for all medical bills and other charges that result from services rendered by Hand & Orthopedic Physical Therapy Specialists.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the provider and is not a substitute for payment. Regardless of insurance coverage you are responsible for all balances incurred. Some insurance companies may pay fixed allowances for certain procedures, sometimes referring to these as "Reasonable and Customary Fees." We do not accept this as payment in full, unless otherwise restricted by law or contract agreement we may have with your insurance carrier(s). Many insurance companies pay only a percentage of the charge, leaving it your responsibility to pay any deductible amount, co-insurance amount, co-pays (due at each visit) and any other balance not covered by your insurance carrier(s). As a courtesy, our office may inform you of the benefits we were quoted by your insurance carrier(s). However, this is not a guarantee of your actual benefit plan or payment. If you have any further questions, please contact your insurance carrier(s).

ASSIGNMENT OF BENEFITS: I hereby assign all medical/physical-occupational therapy benefits, to which I am entitled, Medicare, private insurance and other health plans to: Hand & Orthopedic Physical Therapy Specialists. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment, via fax transmittal or hard copy. Medical records will be accessible to all physical/occupational therapists of Hand & Orthopedic Physical Therapy Specialists.

INJURIES AT WORK: In the event it is determined by your industrial/Workman's Compensation insurance that the illness/injury is not a result of a compensated Workman's Compensation case, you will be responsible to pay usual and customary fees for services rendered. If you do not have your information at this time, please get it to us within 24 hours before your account is turned over to Self Pay status.

AUTO ACCIDENTS: Auto insurance claims will be billed to YOUR auto carrier, not to any other parties' auto carrier due to Utah's No Fault Law. If your auto PIP exhausts, which in many cases is true, as you may have already been to the emergency room, had surgery, etc, we will bill your health insurance that you have provided. If you wish to not have your health insurance billed, you will be responsible for all charges. If you do not have your information at this time, please get it to us within 24 hours before your account is turned over to Self Pay status.

PERSONAL INJURY: If you are dealing with a lawsuit or claim, we require verification from your attorney, as well as a lien agreement that we may keep on file and a monthly payment plan. Please remember even if you have an attorney you are ultimately responsible for your bill and need to update our office on the status of your case frequently.

SUPPLIES: Frequently, therapy supplies and/or splints are recommended to expedite your recovery. Unfortunately insurance companies do not cover these items. Therefore, if your therapist suggests these items, it will be your responsibility and your decision to purchase these items. We will provide you with a receipt to bill your insurance if you choose to do so. Used or opened items are non returnable/refundable. Supplies are to be paid for at the time of service. If we have to bill you for a supply you will incur an extra service charge.

PAST DUE ACCOUNTS: An account becomes past due 30 days after it becomes patient responsibility. Your balance will be communicated. If your account becomes past due, we will take necessary steps in contacting you to collect this debt. If these attempts do not generate a response from you, your account could be subject to the following fees: Finance Charges (currently 18%), In House Collection Fees, Collection Agency fees and any Attorney fees.

RETURNED CHECKS: There is a fee (currently $20) for any checks returned by the bank.

MISSED APPOINTMENT FEE: The second time a patient does not show up on time for an appointment or cancels with less than 24 hours notice, a $45 fee will be charged. This fee must be paid before a new appointment is scheduled.

SELF PAY ACCOUNTS: If you do not have health insurance we do offer self pay plans. Self Pay payments are due at the time of service. Please speak to our Patient Advocate or a member of our billing staff for more information. If you are unable to provide us with your health insurance, worker's compensation insurance or personal injury insurance within 24 hours of your first visit you will automatically be turned over to a self pay account status. Even if you provide us with your insurance information after the initial 24 hour period we reserve the right to refuse to bill your insurance.

MONTHLY STATEMENT: If you have a balance on your account, we will send you a monthly statement. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable on or before the due date specified on the statement and is past due if not paid on or before that date. We do charge interest (18%) on all past due accounts; interest will begin accruing once the account becomes 60 days past due.

**In signing this agreement, I consent to a therapy evaluation and subsequent treatment provided and directly supervised by a licensed physical/occupational therapist and/or physical/occupational therapy assistant employed by Hand & Orthopedic Rehabilitation Specialists as well as agree to all of the terms and conditions contained herein and the agreement will be in full effect.**

**Patient's Name:** _____

**Responsible Party** (if not patient or if patient is a minor): _____

**Signature:** _____ **Date:** _____

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") 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 properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required, we have prepared this explanation of how we are required to maintain this 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. We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to 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 request, 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 of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we dc 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 amend 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 _____, 20_____ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and 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 that your privacy protections have been violated. You have the right to file written complaint with our office, 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.

For more information about HIPPA or to file a complaint please contact Carrie Davis, Privacy Officer (801) 261-3321.

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (Print): _____ Relationship to Patient: _____

Signature: _____ Date: ____/____/_____

Hand & Orthopedic
Physical Therapy Specialists

**Name**: _____ **Date**: _____

Have you had physical therapy previously this year? YES____ NO ____ How many visits? ____

## Surgical/Prescription History

#1. Please list any surgeries and the approximate year you had them:

| Surgery: | Date: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

#2. Please list all current medications and the condition they are treating. This includes vitamins and supplements. If you have a current list prepared please provide it to the reception staff and skip this section:

| Medication: | Dosage: | Reason: |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Please continue on back in necessary.