New Patient Information **Date:_____** **Account No._____**

Patient Name:_____ E-Mail Address:_____ Age:_____ Sex: M F

Social Security No:_____ Date of Birth:_____ Marital Status: S M W Home Phone:_____

Mailing Address:_____City/State/Zip:_____

Employer:_____Occupation:_____Cell Phone:_____

Employer Address:_____ Work Phone Number:_____

Spouse (or parent, if minor):_____ Spouse or Parent Employer:_____

Contact Person Outside Home:_____ Phone No.:_____ Relation to Patient: _____

Referring Physician:_____ Primary Care Physician:_____

Attorney Name: _____Attorney Phone No: _____Date of Injury:_____

Billing Information (Please present insurance card)

Workers Comp_____Auto Accident_____Medicare_____Blue Cross_____Cigna_____United Health_____PHCS _____Other_____

If you want us to bill under workers comp or for an auto accident, we will do so but we ask that you present us with your personal health insurance information as back up.

I do not wish to provide a copy of my private health insurance card. I realize that if my workers comp or auto claim should be denied that I would be responsible for any charges incurred. Please Sign_____

Primary Insurance:_____Primary Insured:_____Relation to Patient: _____

Primary Insured's Social Security No.:_____ Primary Insured's Date of Birth: _____

Primary Insured's Mailing Address: _____ City/State/Zip: _____

Secondary Insurance:_____Subscriber Name:_____

Subscriber Date of Birth:_____ Subscriber Social Security Number: _____

DID YOU COME TO OUR CLINIC ON THE RECOMMENDATION OF YOUR PHYSICIAN? _____ YES _____ NO IF NO, BECAUSE OF _____ FRIEND _____ NEWSPAPER _____ YELLOW PAGES _____ ATTORNEY OTHER _____

CONSENT TO PHYSICAL THERAPY

1. **I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of services and fully understand that I am financially responsible for any services not covered by this authorization.**
2. **I have presented myself to this facility for physical therapy treatments and consent to diagnostic procedures and care provided by my attending physical therapist. I authorize release of all information relating to this account/file to any person pertinent to this account including but not limited to insurance companies, employer, physician, attorney, case management firm or agent thereof.**
3. **I realize I have the right to refuse any drugs, treatments, and procedures to the extent permitted by law. I acknowledge that medicine is not an exact science, no guarantees or warranties can be made to me regarding the results of any treatments at this facility. I understand that information from any medical record(s) kept by this facility may be used for educational administrative, and/or facility approved purposes when my personal identity will not be revealed.**
4. ****NOTE TO WORKERS COMP** I hereby authorize my rehab consultant to receive my records related to my work injury. This information may be faxed or mailed.**
5. **I understand I am contractually responsible for payment of my account in full and if my account has to be turned over to collections, I will be responsible for any collection fees, attorney's fees, court costs, and any other cost incurred to collect this account (not applicable for accounts covered by Workers' Compensation). I further understand that all accounts with checks returned unpaid will be assessed a fee of $25.00 and that interest will be charged on all overdue accounts at 12% APR.**

I HAVE READ AND FULLY UNDERSTAND THE ABOVE GENERAL CONSENT FORM AND ANY QUESTIONS I MAY HAVE HAD, HAVE BEEN ANSWERED TO MY SATISFACITON.

_____ **DATE:**_____

SIGNATURE OF PATIENT (if the patient is a minor {under 18 yrs of age} parent must sign)

DATE:

BILLING DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please take a few moments to complete this form.

I authorize OSPT to disclose my health information that is directly related to my current treatment at OSPT to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

Such persons involved in your care may include spouses, children, blood relatives, roommates, boyfriends or girlfriends, domestic partners, neighbors and colleagues.

NAME	RELATIONSHIP

I do not wish to have my health information disclosed to the individuals below even though involved in my care.

NAME	RELATIONSHIP

_____ _____

Signature of Patient (or Patient's Representative) **Date**

_____ _____

Signature of Witness (OSPT Staff) **Date**

If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:

☐ Power of Attorney ☐ Guardian ☐ Surrogate Decision-Maker
☐ Executor of Legal Rep. ☐ Parent ☐ Other (please specify) _____

_____

Provide documentation or explanation of your authority to act for the patient

_____

OSPT'S NOTICE OF PRIVACY PRACTICES
Effective April 14, 2003

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

The terms of this Notice of Privacy Practices apply to **Orthopedic & Sports Physical Therapy** only.

We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to personal health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make a new Notice effective for all personal health information maintained by Orthopedic & Sports Physical Therapy. We are also required to inform you that there may be a provision of State law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act. A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer, OSPT 245 N. College Rd Lafayette, LA 70506.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

Authorization and Consent: Except as outlined below, we will not use or disclose your personal health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization.

Uses and Disclosures for Treatment: With your agreement, we will make uses and disclosures of your personal health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history etc.

Uses and Disclosures for Payment: With your agreement, we will make uses and disclosures of your personal health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations: With your agreement, we will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and patient care.

Individuals Involved In Your Care: With your written agreement we may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with involved individuals without your approval. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment reminders or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You may make your requests by sending your name and address to Privacy Officer, 245 N. College Rd Lafayette, LA 70506.

Research: In limited circumstances, we may use and disclose your personal health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional review board which oversees the research or by representations of the researchers that limit their use and disclosure of patient information.

Other Uses and Disclosures:
We are permitted and/or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization for the following:

- any purpose required by law.
- public health activities, such as required reporting of disease, injury, birth and death, or required public health investigations.
- if we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect, or domestic violence.
- to the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls.
- to your employer when we have provided health care to you at the request of your employer;
- to a government oversight agency conducting audits, investigations, or civil or criminal proceedings.
- court or administrative ordered subpoena or discovery request;
- to law enforcement officials as required by law to report wounds and injuries and crimes;
- to coroners and/or funeral directors consistent with law;
- if necessary to arrange an organ or tissue donation from you or a transplant for you;
- if you are a member of the military; we may also release your personal health information for national security or intelligence activities; and
- to workers' compensation agencies for workers' compensation benefit determination.

RIGHTS THAT YOU HAVE REGARDING YOUR PERSONAL HEALTH INFORMATION:

Access to Your Personal Health Information
You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person.

Amendments to Your Personal Health Information
You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, must be in writing, signed by you or your legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical records.

Accounting for Disclosures of Your Personal Health Information
You have the right to receive an accounting of certain disclosures made by us of your personal health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Personal Health Information: You have the right to request restrictions on uses and disclosures of your personal health information for treatment, payment, or health care operations. We are not required to agree to your restriction request, but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the individual responsible for medical records.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer, OSPT 245 N. College Rd Lafayette, LA 70506. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

ALL PATIENTS:

I certify that I have been presented with the Health Insurance Portability and Accountability Act (HIPAA) from Orthopedic and Sports Physical Therapy.

If you have questions or need further assistance regarding this Notice, you may contact the Privacy Officer, OSPT 245 N. College Rd Lafayette, LA 70506

_____ _____

Patient Signature **Date**

LIABILITY PATIENTS ONLY:

I, _____, agree that OSPT, LLC can bill my account through the following entity _____.

_____ _____

Patient Signature **Date**

HEALTH INSURANCE PATIENTS ONLY:

I acknowledge that I understand the provisions of my health insurance benefits. I understand that these benefits are a matter of contract between me and my insurance carrier.

_____ _____

Patient Signature **Date**

_____ _____

Witness Signature (OSPT Staff) **Date**