OUACHITA
PHYSICAL THERAPY

1138 Oliver Road • Monroe, LA 71201
Phone (318) 323-3031 • Fax (318) 323-3040
www.OptForTheBest.com

Patient Name:_____

Street Address:_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Date of Birth:_____ Age:_____ SSN:_____

Please check one: _____Married _____Single _____Widowed _____Divorced

Place of Employment:_____ Job Title:_____

****** The following information is required for billing purposes ******

Spouse Name:_____

Spouse Date of Birth:_____ SSN:_____

Do you have supplement insurance? _____Yes _____No

Insurance Name:_____

Emergency Contact:_____

Relationship:_____ Phone Number:_____

Referred by:_____ Next Visit:_____

Primary Physician:_____

IF YOU HAVE MEDICARE AS A PRIMARY INSURANCE, ARE YOU CURRENTLY RECEIVING ANY HOME HEALTH SERVICES? _____Yes _____No
IF YES, NAME OF HOME HEALTH:_____

Is your visit today due to an accident? _____Yes _____No

If due to an accident, describe:_____

Have you retained an attorney? _____Yes _____No

If yes, Attorney's name:_____ Phone Number:_____

Patients receive EOBs from Medicare; therefore, Ouachita Physical Therapy is not responsible to provide financial records. It is each patient's individual responsibility to obtain and keep financial EOBs from Medicare. Ouachita Physical Therapy will provide health records to patients as needed, but will not provide financial statements. There is a charge for health record copies.

I HAVE READ AND UNDERSTAND THIS STATEMENT. I GIVE PERMISSION TO BE TREATED BY OUACHITA PHYSICAL THERAPY, INC., AS ORDERED BY MY PHYSICIAN.

_____ _____

Patient Signature **Date of Signature**

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Primary Insurance

Name of Subscriber:_____ Birth date:_____

Relationship to Patient: Self Spouse Parent Other:_____

Phone Number:_____ SSN:_____

Insurance Company:_____

Subscriber Number:_____ Phone Number:_____

Subscriber's Employer:_____

Secondary Insurance If you have no secondary coverage, initial here:_____

Name of Subscriber:_____ Birth date:_____

Relationship to Patient: Self Spouse Parent Other:_____

Phone Number:_____ SSN:_____

Insurance Company:_____

Subscriber Number:_____ Phone Number:_____

Subscriber's Employer:_____

I give my permission for Ouachita Physical Therapy to leave messages per the following:

Answering Machine/Voicemail? Yes No Phone Number:_____

Email? Yes No Email Address:_____

Text Messages? Yes No Phone Number:_____

Patient's Signature:_____

I give my permission for Ouachita Physical Therapy to discuss my medical condition with:

Name:_____ **Relation:**_____

Home Phone:_____ **Cell Phone:**_____

Patient's Signature:_____

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Medical History

Existing Conditions					
Allergies	☐Yes ☐No	Depression	☐Yes ☐No	Multiple Sclerosis	☐Yes ☐No
Anemia	☐Yes ☐No	Diabetes	☐Yes ☐No	Osteoporosis	☐Yes ☐No
Anxiety	☐Yes ☐No	Dizzy Spells	☐Yes ☐No	Parkinsons	☐Yes ☐No
Arthritis	☐Yes ☐No	Emphysema/Bronchitis	☐Yes ☐No	Rheumatoid Arthritis	☐Yes ☐No
Asthma	☐Yes ☐No	Fractures	☐Yes ☐No	Seizures	☐Yes ☐No
Cancer	☐Yes ☐No	Gallbladder Problems	☐Yes ☐No	Speech Problems	☐Yes ☐No
Cardiac Conditions	☐Yes ☐No	Hepatitis	☐Yes ☐No	Strokes	☐Yes ☐No
Cardiac Pacemaker	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Thyroid Disease	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Incontinence	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Circulation Problems	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Vision Problems	☐Yes ☐No
Currently Pregnant	☐Yes ☐No	Metal Implants	☐Yes ☐No		

Describe any other conditions or precautions

Fall History

Injuries as a result of a fall in the past year? ☐Yes ☐No
Two or more falls in the past year? ☐Yes ☐No

Surgical History

Body Region:_____ Surgery Type:_____ Date:_____

Body Region:_____ Surgery Type:_____ Date:_____

Body Region:_____ Surgery Type:_____ Date:_____

Body Region:_____ Surgery Type:_____ Date:_____

Current Medications

Drug:_____ Dosage:_____ Frequency:_____ Route:_____ Reason Taking:_____

Drug:_____ Dosage:_____ Frequency:_____ Route:_____ Reason Taking:_____

Drug:_____ Dosage:_____ Frequency:_____ Route:_____ Reason Taking:_____

Drug:_____ Dosage:_____ Frequency:_____ Route:_____ Reason Taking:_____

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Appointment Policy

I understand that my doctor has prescribed therapy for me and that physical therapy is an ongoing process which requires regular attendance to be optimally effective. I understand that if I am late for an appointment, I may have to reschedule my appointment or may have to accept an abbreviated treatment for that day. I understand that if I cancel or no show for three consecutive appointments, Ouachita Physical Therapy has the right to discharge me from care for being non-compliant with my physician's orders.

I understand and agree that Ouachita Physical Therapy requires a 24-hour advance notice of cancellation. If I fail to give 24-hour notice of cancellation or fail to show up for an appointment, I may be subject to a $25 charge (which is not covered by insurance).

_____ _____

Patient's Signature Date

(Parent of legal guardian must sign if patient is under 18 years of age)

Relationship to patient: Mother Father Legal Guardian

Authorization for Treatment

I hereby consent to and authorize all therapy treatments, which in conjunction with the judgment of my attending physician, may be considered necessary and/or advisable for the diagnosis and/or treatment of the patient named above at Ouachita Physical Therapy, Inc.

_____ _____

Patient's Signature Date

(Parent of legal guardian must sign if patient is under 18 years of age)

Relationship to patient: Mother Father Legal Guardian

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Financial Policies

Please read each of the detailed policies below. If you have any questions, please discuss them with our staff. If you understand and accept each policy, please initial the blank provided, sign, and date below.

_____**HEALTH INSURANCE FILING POLICY:** Your health insurance will be billed periodically as you receive treatment. A statement will be mailed to you reflecting the payments received from your insurance company and the balance owed. Prompt payment with in thirty (30) days is expected.

_____**COLLECTION POLICY:** Delinquent accounts are very costly. Therefore, to avoid any misunderstanding, our procedures in notifying our patients of their financial responsibility are:

- Three (3) attempts by regular mail will be made to contact you. If our mail is returned as undeliverable, attempts will be made to contact you through additional information in your chart.
- If our attempt to contact you fail and your account remains unpaid, your account will be turned over to our Collection Agency. Upon assignment to our Collection Agency, a service charge of 32% will be added to your account balance.
- In the event of a lawsuit must be filed to collect your account balance, you will be required to pay attorney fees and court costs.

_____**CASH PAYMENT POLICY:** A cash payment policy is available to patients whose insurance does not cover physical therapy or if there is limit coverage insufficient for the patients needs. Payment will be required at the time of treatment under this plan and MUST be discussed PRIOR to treatment.

PATIENT RESPONSIBILITY: I have read the above detailed financial policies. I understand that I am fully responsible for any and all charges indicated to be patient responsibility.

_____	_____	_____
Patient Signature	Witness	Date

Liability Patients

Were you referred for physical therapy due to an accident? _____Yes _____No

If you checked 'yes', our policy is as follows:
We will not file your health insurance unless that insurance requires we file through Subrogation. (An explanation of "subrogation" is available upon request.) Should you retain an attorney or involve an accident insurance company, we will be glad to wait until the case is settled to recoup our billing charges. This is not a new policy; we have extended this option. However, should we file your health insurance which requires we accept an adjustment to our charges, we retain the right to recoup the adjustment from the patient if a settlement is reached through other channels. **If our billed charges are used to reach settlement, we are due 100% of our billing charges. NO EXCEPTIONS.**

I have read the above policy for liability patients and understand my obligations regarding payment.

_____	_____	_____
Patient Signature	Witness	Date

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Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

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Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Rights

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.

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Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

Help with public health and safety issues

We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

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Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

The effective date of this notice is September 23, 2013.

I, _____, acknowledge receipt of this Notice of Health
(print patient's name)
Information Privacy Practices.

_____ _____
Patient's Signature Date

_____
Printed Name

FOR OUACHITA PHYSICAL THERAPY STAFF USE ONLY

Failure to Obtain Acknowledgment of Receipt of Notice of Health Information Privacy Practices

I, _____, (staff member) certify that I have made a good faith effort to obtain written acknowledgment of Receipt of this Notice of Health Information Privacy Practices, but the acknowledgment was not obtained because:

_____

_____

_____ _____
Staff Member Signature Date