PATIENT INFORMATION AND CONSENT

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____City:_____State:_____Zip:_____

Home Phone: _____ Date of Birth: _____ Age: _____ Male ☐ Female☐

Cell Phone: _____ Appt Reminder: ☐Text ☐ Email ☐None Cell Carrier(*if text reminder*):_____

Social Security Number: _____ Marital Status: S M D W (circle one)

Email Address: _____

Employer: _____ Work Phone: _____ Occupation: _____

Address: _____City:_____ State: _____ Zip:_____

EMERGENCY CONTACT INFORMATION

Name: _____ Phone: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

SOC Date: _____Date of Onset: _____ Surgery Date: _____

Referring Physician: _____ NPI#: _____ Diagnosis: _____

WORK RELATED: Yes☐ No ☐ AUTO ACCIDENT: Yes ☐ No☐ OTHER LIABILITY INSURANCE: Yes ☐ No☐

PRIMARY INSURANCE:

Payer: _____

Payer Address: _____

Policyholder Name: _____

DOB: _____ SSN: _____

Relationship of Patient to Insured:

_____ Self _____ Spouse

_____ Child _____ Other

Group ID#:_____

ID#:_____

SECONDARY INSURANCE:

Payer: _____

Payer Address: _____

Policyholder Name:_____

DOB: _____ SSN: _____

Relationship of Patient to Insured:

_____ Self _____ Spouse

_____ Child _____ Other

Group ID#:_____

ID#:_____

The Physical, Occupational and Speech Therapy Program has been prescribed by your physician. Your signature gives us permission to implement this treatment. I authorize the staff at Regional Therapy Services to discuss protected health information with caregivers involved in treatment of the above listed patient. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act, other applicable federal and state acts, or other insurance policies is correct. I authorize to release to any insurance company or their agent, any information needed for this or related claim. I request payment of authorized benefits be made on my behalf directly to Regional Therapy Services, Inc. for any past or future services rendered to me. We will verify insurance coverage upon evaluation; however, this is not a guarantee of payment. You are responsible for reviewing your insurance plan and knowing your coverage limitations for therapy services. I understand that I will be responsible for payment of services rendered.

_____

Signature Date

_____

Relationship (if signer is not patient)

This provider of Medical Services is an equal opportunity employer and does not discriminate in its professional or employment practices of the basis of race, creed, color, sex, national origin, age, or handicap.

Cancellation/No Show Policy

To assist you with our best care, please follow our policy concerning your appointments:

- If you cannot attend your scheduled appointment, PLEASE cancel as early as possible. Another patient may be able to benefit from the time allotted.
- Two or more "No Shows" may result in your discharge from therapy.
- If you cancel or "No Show" for more than 50% of your appointments in any two week period, you may be discharged from therapy.

Thank you for your cooperation.

_____ _____

Signature of Patient or Representative of Patient Date

Splints or Supplies

Patients are responsible for payment of splints or supplies at the time of receipt. We will be glad to give you a receipt for your records or for you to file with your personal health insurance.

Note: Patients seen under workers compensation claims will need an order from their attending physician for us to obtain prior approval from workers compensation for payment of splints.

_____ _____

Signature of Patient or Representative of Patient Date

Authorization for Release of Medical Information

This form is kept on file until the patient requests to release their medical information to a specified person/company.

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

Information Released From: _____

Information Released To: _____

Relationship to Patient: _____

List any tests performed in the last year (MRI, X-Ray, etc.): _____

_____

Purpose for Release: _____

_____ _____
Signature of Patient or Representative of Patient Date

_____ _____
Signature of Agency Date

CONTACT INFORMATION AND HOW TO REPORT A PRIVACY RIGHTS VIOLATION

If you have questions and/or would like additional information regarding the uses and disclosures of your health information, you may contact our Privacy Officer at:

Address:	**Attn: Privacy Officer** 300 Sunset Circle Moultrie, GA 31768
Telephone:	229-985-2080
Fax:	229-890-3397

If you believe your privacy rights have been violated or that we have violated our own privacy practices, you may file a complaint with us. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. Complaints filed directly with the Secretary must be made in writing, name us, describe the acts or omissions in violation of the Privacy Rules or our privacy practices, and must be filed within 180 days of the time you knew or should have known of the violation. Complaints submitted directly to us must be in writing and to the attention of our Privacy Officer. There will be no retaliation for filing a complaint.

BY SIGNING BELOW, I HEREBY ACKNOWLEDGE RECEIPT OF THIS PRIVACY NOTICE.

_____ _____

Printed Name of Patient Date (Effective Date of Notice)

_____

Signature of Patient or Representative of Patient

_____

Printed Name of Patient's Representative (*if applicable*)

_____

Representative's Relationship to Patient (*if applicable*)

To be completed by Regional Therapy Services, Inc.:

After a good faith attempt to obtain an Acknowledgment of Receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s): _____

_____

_____

_____ _____

Signature of Regional Therapy Service, Inc. Representative Date

We are so happy to have you… and we would love to thank who sent you!

We are truly looking forward to working with you. Please take a few moments to answer the following question.

Patient Name: _____ Date: _____

Diagnosis: _____

Referring Physician Name: _____ Primary Care Physician: _____

Services being utilized: (Please circle all that apply)

Physical Therapy **Occupational Therapy** **Speech Therapy**

How did you hear about our facility? (Place an **X** on which applies)

_____My physician told me to come here.

_____My physician's assistant told me to come here.

_____My physician's nurse told me to come here. If so, who: _____

_____The receptionist at my physician's office suggested that I come here. If so, who: _____

_____My case manager told me to come here. If so, who: _____

_____My physician gave me a list of choices and asked me for my preference.

_____My physician's assistant gave me a list of choices and asked for my preference.

_____My physician's nurse gave me a list of choices and asked for my preference. If so, who: _____

_____The receptionist at my physician's office called and arranged my therapy. If so, who: _____

_____The facility was listed as a part of my insurance plan.

_____A friend recommended this facility. If so, who: _____

_____I have been here before.

Other: _____Newspaper Ad _____Radio _____Yellow Pages _____White Pages

Other, please explain: _____

PATIENT RIGHTS

You may keep this page for your records.

You have the following rights concerning your Health Information:

1. **Right to Inspect and Copy Your Health Information.** Upon written request, you have the right to inspect and copy your own Health Information contained in a designated record set, maintained by or for us. A "designated record set" contains medical and billing records and other records that we use for making decisions about you. However, we are not required to provide you access to all the Health Information we maintain. For example, the right of access does not extend to psychotherapy notes, or information compiled in reasonable anticipation of, or for us in, a civil, criminal or administrative proceeding. Where permitted by the Privacy Rules, you may request that certain denials to inspect and copy your Health Information be reviewed. If you request a copy or summary of explanation of your Health Information, we may charge you a reasonable fee for copying costs, including the cost of supplies and labor, postage, and any other associated costs in preparing the summary or explanation.
2. **Right to Request Restrictions on the Use and Disclosure of Your Health Information.** You have the right to request restrictions on the use and disclosure of your Heath Information for treatment, payment and health care operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. We will consider, but do not have to agree to, such requests.
3. **Right to Request an Amendment of Your Health Information.** You have the right to request an amendment of your Health Information. We may deny your request if we determine that you have asked us to amend information that: was not created by us, unless the person or entity that created the information is no longer available; is not Health Information maintained by or for us; is Health Information that you are not permitted to inspect or copy; or we determine that the information is accurate and complete. If we disagree with your requested amendment, we will provide you with a written explanation of the reasons for the denial, an opportunity to submit a statement of disagreement, and a description of how you may file a complaint.
4. **Right to an Accounting of Disclosures of Your Health Information.** You have the right to receive an accounting of disclosures of your Health Information made by us within six (6) years prior to the date of your request. The accounting will not include: disclosures related to treatment, payment or health care operations; disclosures to you; disclosures based on your Authorization; disclosures that are part of a Limited Data Set; incidental disclosures; disclosures to persons involved in your care or payment for your care; disclosures to correctional institutions or law enforcement officials; disclosures for facility directories; or disclosures that occurred prior to April 14, 2003.
5. **Right to Alternative Communications.** You have the right to receive confidential communications of your Health Information by a different means or at a different location than currently provided. For example, you may request that we only contact you at home or by mail. On occasions we may leave a message for the patient at work, home, daycares or designated contact pertaining to your services with Regional Therapy Services, Inc.
6. **Right to Receive a Paper Copy of this Privacy Notice.** You have the right to receive a paper copy of this Privacy Notice upon request, even if you have agreed to receive this Privacy Notice electronically.