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. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires 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 by "HIPAA", we have prepared this explanation of how we are required to maintain the 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 operation.

- TREATMENT means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be sending medical information to the referring physician.
- PAYMENT means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill and/or chart notes for your visit to your insurance company for payment.
- HEALTH CARE OPERATIONS include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing function, cost management analysis, and customer service. An example would be sending charts to the physical therapy network for quality assurance and review.

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, reschedule appointments, or provide 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 do 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 April 14, 2003 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 copy of the 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 a 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 HIPAA or to file a complaint:
The US Department of Health & Human Services
Office of Civil Rights
200 Independence Ave SW
Washington, DC 20201
Toll Free: 10877-696-6775

Patient Initials:_____

New Patient Form

Personal Information

Patient Name: _____ Date:_____
Address: _____ City:_____Zip: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____ Age:_____ Date of Birth:_____
Social Security Number: _____ How did you hear of us? _____
Would you like to receive appointment reminders by email?
□ Yes, Notify me by email. □ No, Do not email me.
Would you like to receive appointment reminders via text message?
□ Yes, Notify me by text. □ No, Do not text me.
Gender: Marital Status:
□ Male □ Female □ Single □ Married □ Widowed
Follow up date with Physician:_____
Date of Injury: _____
Employer:_____ Occupation: _____
Emp. Address:_____ City: _____Zip: _____
Work Phone:_____

Primary Insurance

Name of Subscriber:_____ Birthdate: _____
Relationship to Patient: □ Self □Spouse □Parent □Other:_____
Address of Subscriber: _____
(If Different than Patient) Street Address City State Zip
Phone #'s: (_____) _____-_____ (_____) _____-_____
(If Different than Patient) Home Phone Cell Phone
Insurance Co:_____ Provider Phone #: _____
Subscriber #: _____ Group #: _____

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Patient Initials:_____

Secondary Insurance

Name of Subscriber:_____ Birthdate: _____
Relationship to Patient: □ Self □Spouse □Parent □Other:_____
Address of Subscriber: _____
(If Different than Patient) Street Address City State Zip
Phone #'s: (_____) _____-_____ (_____) _____-_____
(If Different than Patient) Home Phone Cell Phone
Insurance Co:_____ Provider Phone #: _____
Subscriber #: _____ Group #: _____

Insurance Information for Workers Compensation/ Auto Accident

Adjuster/Claims Rep:_____ Phone Number:_____
Claim #:_____

Emergency Contact Information

Name:_____ Name:_____
Relationship to Patient:_____ Relationship to Patient:_____
Phone Number:_____ Phone Number:_____

I have received and understand my rights as described in the Notice of Privacy Practices.

Signature:_____ Date:_____

Patient Initials:_____

Medical History

Existing or Relevant Previous Conditions

Allergies	O Yes O No	Hepatitis	O Yes O No
Anemia	O Yes O No	High Cholesterol	O Yes O No
Anxiety	O Yes O No	High/Low Blood Pressure	O Yes O No
Arthritis	O Yes O No	HIV/AIDS	O Yes O No
Asthma	O Yes O No	Incontinence	O Yes O No
Autoimmune Disorder	O Yes O No	Kidney Problems	O Yes O No
Cancer	O Yes O No	Metal Implants	O Yes O No
Cardiac Conditions	O Yes O No	MRSA	O Yes O No
Cardiac Pacemaker	O Yes O No	Multiple Sclerosis	O Yes O No
Chemical Dependency	O Yes O No	Muscular Disease	O Yes O No
Circulation Problems	O Yes O No	Osteoporosis	O Yes O No
Currently Pregnant	O Yes O No	Parkinsons	O Yes O No
Depression	O Yes O No	Rheumatoid Arthritis	O Yes O No
Diabetes	O Yes O No	Seizures	O Yes O No
Dizzy Spells	O Yes O No	Smoking	O Yes O No
Emphysema/Bronchitis	O Yes O No	Speech Problems	O Yes O No
Fibromyalgia	O Yes O No	Strokes	O Yes O No
Fractures	O Yes O No	Thyroid Disease	O Yes O No
Gallbladder Problems	O Yes O No	Tuberculosis	O Yes O No
Headaches	O Yes O No	Vision Problems	O Yes O No
Hearing Impairment	O Yes O No		

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other conditions

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Patient Initials:_____

Fall History

Injury as a result of a fall in the past year? O Yes O No

Patient is at risk for falls? O Yes O No

Surgical History

1. Body Region: _____ Surgery Type: _____ Date: _____,_____,_____

2. Body Region: _____ Surgery Type: _____ Date: _____,_____,_____

3. Body Region: _____ Surgery Type: _____ Date: _____,_____,_____

4. Body Region: _____ Surgery Type: _____ Date: _____,_____,_____

Current Medications

1. Drug: _____ Dosage: _____ Frequency: _____ Route: _____
Reason for Taking:_____

2. Drug: _____ Dosage: _____ Frequency: _____ Route: _____
Reason for Taking:_____

3. Drug: _____ Dosage: _____ Frequency: _____ Route: _____
Reason for Taking:_____

4. Drug: _____ Dosage: _____ Frequency: _____ Route: _____
Reason for Taking:_____

☐ **Currently not taking any medications**

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Assignment of Benefits and Financial Policies

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with us prior to beginning therapy.

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to us. In other words, you agree to have your insurance company pay us directly. If your insurance company does not pay us within a reasonable time period, we will have to look to you for payment of the outstanding balance.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an out-of-network basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payments for services are due at the time of service.
- You must inform our office of all insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges that are denied.
- For all services rendered to minors, we will look to the parent/guardian accompanying the patient for payment.
- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the copayment at the time of service. If you have a copay, you may either pay each time you come for your appointment or you may pay in advance to cover all visits for the week. Once the insurance company has begun to process our bills, if there is a balance due, we will send you a statement each month for the amount you owe – i.e. deductible, coinsurance, copay, until all claims have been processed. Payment is due upon receipt of our bill.
- All health plans are not the same and do not cover the same services. We will do our best to determine what services are covered by your insurance and let you know if there is a recommended treatment that is not a benefit of your insurance so that you may decide to proceed with the treatment or elect not to have the treatment performed. In the event your health plan determines a service to be “not covered” and we are unaware or you do not have authorization, you will be responsible for the complete charge.

Payments and Patient Signature

- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees, and court fees shall become your responsibility in addition to the balance due this office.
- There is a $20.00 service fee for all returned checks. Your insurance company does not cover this fee.
- A $30.00 fee will be charged for all “No Shows” and Cancellations without a 24-hour notice. This fee is not reimbursable by insurance.
- I have read and understand the financial policy of Lakeside Physical Therapy and I agree to be bound by its terms. I also understand that such terms may be amended from time to time by this office.
- I authorize the release of information necessary for treatment, payment and health care operations. I also authorize assignment of benefits for services rendered by Lakeside Physical Therapy.

Patient Signature: _____ Date: _____

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