REHABILITATION & Performance Center
PHYSICAL THERAPY

# PATIENT INFORMATION FORM

Today's Date: _____

Patient Name:_____ Sex: M ☐ F ☐

Date of Birth: _____ Marital Status: _____ Email address: _____

Address:_____ Apt/Lot#: _____

City:_____ State: _____ Zip code : _____

Phone: _____ HOME _____ CELL _____ WORK _____ EMERGENCY # / CONTACT / RELATION TO PATIENT

Please list any person able to have access to your medical records: ☐ N/A

Name _____ Relationship to Patient_____

**Referring Physician: _____ Next Appointment: _____**

***Complete this section *ONLY* if your treatment is the result of a WORK INJURY or AUTO ACCIDENT**

Do you have an attorney? Y ☐ N ☐ Employer name: _____ Occupation: _____

Is this visit due to a work injury or auto accident? Y ☐ N ☐ Accident / Injury Date: _____

**PAYMENT INFORMATION** (check and initial ONE of the following boxes)

☐ _____**CASH PAYER / I DO NOT have insurance** and I will pay out of pocket with cash, check, or credit card for services. A $35.00 fee will be charged to my account for returned checks and may result in RPC asking for a different form of payment. I will speak with staff about payment options available.

☐ _____**INSURANCE / I HAVE insurance** and want RPC to file all claims for services. I will assign all benefits to RPC and I understand I am responsible for my deductible, co-payment &/or coinsurance associated with my insurance plan for each date of service. I understand that I am financially responsible for any non-covered service(s). It is my responsibility to know my insurance policy and to notify this practice of any changes to my policy and/or coverage.

**Primary Insurance:** _____ Are you the primary policy holder? Y ☐ N ☐

Policy#: _____ Group#: _____

**Secondary Insurance:** _____ Are you the primary policy holder? Y ☐ N ☐

Policy#: _____ Group#: _____

Have you had PT this year? Y ☐ N ☐ If yes, where _____

Do you live in a Nursing Home? Y ☐ N ☐ If yes, where _____

Are you covered under Black Lung Disease? Y ☐ N ☐ Do you receive Home Health Services? Y ☐ N ☐

Are you covered under End Stage Renal Disease? Y ☐ N ☐

**We *LOVE* our referrals! How did you hear about us? ☐Newspaper/column ☐Online Search ☐Family ☐Friend ☐Doctor ☐ Other _____**

REHABILITATION & Performance Center
PHYSICAL THERAPY

# PATIENT INFORMATION FORM

We strive to provide you the best personalized experience. To make this possible we adhere to a set of very important guidelines. **Read carefully. Ask questions. Initial the boxes. Sign the bottom.**

☐ **CONSENT TO TREAT** I allow Lake Oconee Rehabilitation and Performance Center, LLC (RPC) to perform rehabilitation treatment. I have the right to ask about risks and have questions answered about my condition prior to treatment. I understand I will have the opportunity to discuss my condition with the treating physical therapist and that I should notify RPC of any changes to my condition that could affect my response to therapy.

☐ **FINANCIAL POLICIES** Insurance coverage is a contract between me and the insurance carrier. If my insurance company does not remit payment within **60 days**, I will be responsible for the amount due in full. Returned checks are subject to a $35.00 returned check fee and balances older than 30 days may be subject to additional fees and interest charges of 2 percent per month and I will be responsible for any charges incurred due to collection proceedings, attorney fees or court cost. I certify that the information I have provided to RPC for payment including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.

☐ **NOTICE FROM FEDERAL GOVERNMENT** According to the Department of Health and Human Services (HHS), Office of Inspector General (OIG), arrangements for free or discounted care implicate fraud and abuse laws, including the Federal False Claims Act, and the Federal Anti-Kickback Statute. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) it is now a federal crime to defraud private insurance companies. Violations can result in fines and criminal prosecution. **"*It is unlawful to routinely waive co-payments, deductibles, coinsurances or other patient responsibility payments*." (67 Fed. Reg. 72,896 (Dec. 9, 2002)**

☐ **FINANCIAL HARDSHIP** If I am experiencing financial difficulties and are unable to afford the cost of physical therapy services, I can complete a 'Financial Hardship Form' before services are provided. If I qualify for financial assistance according to the federal poverty guidelines, RPC may legally assist. Completing the form is not a guarantee of assistance or release of financial responsibility. Approval is based on financial need. See staff for assistance.

☐ **ASSIGNMENT OF BENEFITS** I authorize direct payment of medical benefits from my insurance carrier(s) to RPC for services delivered. I agree to promptly pay RRPC monies paid directly to me for said services. I authorize the release of any medical information relating to all claims for benefits submitted on behalf of myself and/or dependents.

☐ **CO-PAYS, DEDUCTIBLES, CO-INSURANCE** I understand that any and all payments designated as "the patient's responsibility" "not covered" such as deductibles, co-insurance, and co-payments are due at the time of service and are my financial responsibility.

☐ **REQUEST FOR ELECTRONIC ACCESS / EMAIL COMMUNICATION AUTHORIZATION** I authorize RPC to contact me using email. RPC uses email for communication such as appointment reminders &/or setting up an account portal. Anyone with access to my email can view this information if my email is not secured and thus, will not be protected by federal or state laws. This will remain in force until written termination is received by LORPC at 117 Harmony Crossing, Suite 4, Eatonton, GA 31024 / Attn: Practice Manager. Treatment is not based on signing this authorization.

☐ **CANCELLATION / NO SHOW POLICY** I have received a copy of this policy and understand that if incurred, these charges are my responsibility.

☐ **PRIVACY NOTICE / PATIENT RIGHTS / HIPAA ACKNOWLEDGEMENT** I have received a copy of RPC's Notice of Privacy Practices, HIPAA, and PHI disclosure and use.

| **Your signature acknowledges receipt, acceptance, and your understanding of the above information.** | | |
|---|---|---|
| | | |
| (PRINT) PATIENT NAME | Patient / Responsible Party Signature | Date |

REHABILITATION & Performance Center
PHYSICAL THERAPY

# PATIENT INFORMATION FORM

Legal Name: _____ Gender: M F Age: _____

Leisure Activities: _____ Height: _____ Weight: _____

Referring Doctor: _____ Returning appointment date: _____

Currently seen by: ☐ Medical Doctor ☐ Psychiatrist/Psychologist ☐ Dentist ☐ Physical Therapist ☐ Chiropractor ☐ Osteopath

Onset of current injury/symptoms (date) _____

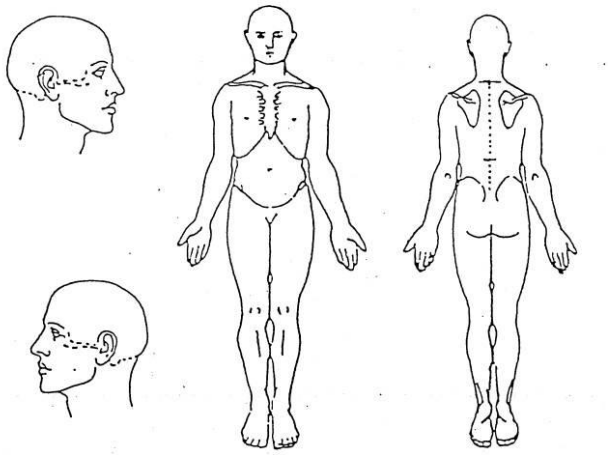
Have you had surgery as a result of your current injury? ☐ Yes ☐ No If yes, date of surgery: _____

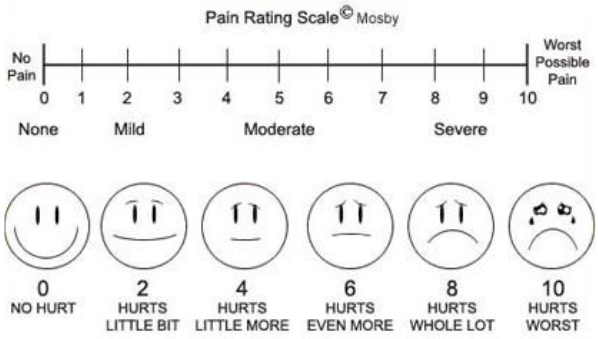
Have you had physical therapy for the current injury/symptoms? ☐ Yes ☐ No

Describe current injury / symptoms: _____

| | | | | | |
|---|---|---|---|---|---|
| Allergies | Yes | No | Gallbladder Problems | Yes | No |
| Anemia | Yes | No | Hepatitis | Yes | No |
| Anxiety | Yes | No | High Blood Pressure | Yes | No |
| Arthritis | Yes | No | Incontinence | Yes | No |
| Asthma | Yes | No | Kidney Problems | Yes | No |
| Cancer | Yes | No | Metal Implants | Yes | No |
| Cardiac Conditions | Yes | No | Multiple Sclerosis | Yes | No |
| Cardiac Pacemaker | Yes | No | Osteoporosis | Yes | No |
| Chemical Dependency | Yes | No | Parkinson's | Yes | No |
| Circulation Problems | Yes | No | Rheumatoid Arthritis | Yes | No |
| Currently Pregnant | Yes | No | Seizures | Yes | No |
| Depression | Yes | No | Speech Problems | Yes | No |
| Diabetes | Yes | No | Strokes | Yes | No |
| Dizzy Spells | Yes | No | Thyroid Disease | Yes | No |
| Emphysema/Bronchitis | Yes | No | Tuberculosis | Yes | No |
| Fractures | Yes | No | Vision Problems | Yes | No |
| Falls | Yes | No | | | |
| 2 or more Falls in past year | Yes | No | | | |
| | | | | | |

**Please circle the locations of your pain**






Other conditions the physical therapist should know about that are not listed above? If yes, please provide:

| |
|---|
| |
| |
| |
| |

REHABILITATION & Performance Center
PHYSICAL THERAPY

# PATIENT INFORMATION FORM

**Patient Legal Name:** _____ **Date:** _____

**Allergies:** ☐ **None** **List allergies here:** _____

_____

**CURRENT PRESCRIBED MEDICATIONS:**

| Medication Name | Reason taken | Dose | Frequency | Route |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

**SURGICAL HISTORY**

| Body Region | Surgery Type | Date / Year of surgery |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| **Your signature acknowledges that all information given is accurate and truthful to the best of your knowledge.** | | |
|---|---|---|
| | | |
| PATIENT NAME (PRINT) | Patient / Responsible Party Signature | Date |

REHABILITATION & Performance Center
PHYSICAL THERAPY

**PATIENT INFORMATION FORM**

**PATIENT COPY**

## PRIVACY NOTICE / PATIENT RIGHTS

EFF 09/2013 / BOM 140/R 062016

This notice is to advise you of how your Protected Health Information (PHI) may be used and disclosed. Rehabilitation and Performance Center, LLC is committed to keeping your health information secure. We are legally obligated to give you this notice. Please review this information carefully.

### Our Uses and Disclosures

- The law permits us to disclose information to those involved in your treatment
- Run our organization
- We may disclose information for billing purposes, seeking insurance or health benefits information, insurance authorization and payment services
- Help with public health and safety issues
- We may use your information to contact you, to remind you of your appointments, for scheduling purposes, leaving messages on a machine or with a person, or to inform you of insurance benefit.
- We will release some or all of your information when requested by law, which includes but not limited to lawsuits / legal actions.
- Address workers' compensation, law enforcement, and other government requests
- Your authorization is required to disclose your health information to other healthcare providers, individuals, or third parties requesting information about you.

### You have the Responsibility to*:*

- Give complete, and accurate and timely medical, personal demographic and payer information to this facility
- Comply with the plan of care to the best of your ability which includes but is not limited to, following home program/instruction, punctually attending scheduled sessions and adhering to known limitations and precautions.
- Advise the therapist when rehabilitative goals or treatment approach requires modification secondary to external complicating factors including but not limited to physical or mental health, family, work or religious conflicts or commitments.
- Adhere to obvious department guidelines while at the facility including but not limited to, courteous interaction with staff, other patients/clients/visitors, conscientious personal hygiene and modesty and respect for treatment and clinical record confidentiality for self and others.
- Provide objective complaint notification to the Owner or designated staff as well as the state Licensing Boards and/or other regulatory agencies if indicated.

### Individual Rights – *You have the Right to*:

- Request a paper / electronic copy of this notice and/or a copy of your medical records at any time.
- Submit a written request to amend incorrect data. Note that an addendum will be added to the record if agreed to amend.
- An accounting of all disclosures and request confidential communications.
- Opt-out of marketing and fundraising efforts. We will not sell personal information without your written permission.
- Restrict certain disclosures of PHI including the right to limit disclosures of information to Medicare or any other payer related to services the individual(s) have paid for out of pocket.
- Choose someone to act for you.
- File a complaint with us, without fear of penalty, if you believe your privacy rights have been violated.

If you believe that your rights have been violated you may also contact:

**Department of Health and Human Services**
**200 Independence Ave. SW, RM 509F**
**Washington, DC 20201**
**1-877-696-6775 or visit on the**
**www.hhs.gov/ocr/privacy/hipaa/complaints/**

You will not be penalized for filing a complaint. Before filing a complaint, we request you ask for assistance regarding the privacy of your healthcare information by contacting Lake Oconee Rehabilitation and Performance Center, LLC at 706-454-1811 or 706-395-3628.

**Breach Notification:** If PHI is breached, either through a covered entity or a covered business associate, updated rules establish mandatory reporting to include the affected individual(s), the Secretary of the US, Department of Health and Human Services, and in some cases the media when covering a breach of unsecured PHI.

A full copy of our Privacy Notice is available upon request.

**PATIENT COPY**

REHABILITATION & Performance Center
PHYSICAL THERAPY

**PATIENT INFORMATION FORM**

## CANCELLATION & NO SHOW POLICIES

**We want all of our patients to receive the maximum possible benefit from physical therapy – but this can only happen if you attend the appointments.**

Our schedules tend to fill up quickly so it is important for you to keep the appointments once they've been made.

**If an appointment is cancelled or missed, we offer no guarantee that an appointment can be rescheduled at the time or date requested.**

### CANCELLATION POLICY

RPC requests at least a 24 hour notice to cancel an appointment. Providing this notice gives our staff time to offer services to another patient who may be waiting for an appointment.

If a 24 hour notice is not provided, a $25.00 charge will be added to your account.

### NO SHOW POLICY

A $25.00 charge will be added to your account for all missed appointments.

### NOTICE TO PATIENTS

I acknowledge the above information. I understand that as with all businesses, it is imperative that I attend my appointments to receive maximum benefits and additionally, I understand and agree to pay any charges associated with any missed or cancelled appointments.

I understand that insurance will not be billed for these charges if incurred and that these charges are solely the responsibility of the patient. I understand if I have three or more missed appointments, any additional appointments may be cancelled from the schedule and a possible discharge from therapy service may result.

---

**PATIENT COPY**

**PATIENT COPY**