AUTO OR NON-WORK RELATED ACCIDENT
Patient & Payor Information Form

All Patients or Patients' Legal Representative, please complete all Sections

(1) Patient: (Full Legal Name or as on Insurance Card)

____
Name: Last First Initial Sr. Jr.

____
Address: Street Apt# City State Zip Code

Phone: (_____) ______-_________ (_____) ______-_________ (_____) ______-_________ (_____) ______-_________
Home Mobile Work Emergency

(2) Patient

Sex: M F

Birthdate: _____/_____/______

S.S # ______/______/_______

Legal Photo ID # ________________________
(Driver's License, Passport, Other State/Federal Photo ID)

(3) Condition to be treated in Physical Therapy: ______________________________

Auto Accident? No Yes Date of Accident ____/____/____

Other Non-Work Related Accident? No Yes Date of Accident ____/____/____

Did this Condition Result in Surgery? No Yes If Yes Date of Surgery ____/____/____

Have You Had PT for this Condition? No Yes If Yes Where?______________________________

Have You Had Chiropractic Services for this Condition? No Yes If Yes Where?______________________________

(4) Patient's Doctor: Please list the Doctor who referred you to therapy below.

____ **Office Phone:** (____) _____-_______
Referring Dr's Name: Last First Initial MD, DO, DDS, Other

____
Address: Street City,State Zip Code

All Patients or Patients' Legal Representative Please Sign Section 9 on Page 3

AUTO OR NON-WORK RELATED ACCIDENT
Patient & Payor Information Form

(5) Auto or Non-Work Accident Claim—

The Claim will be paid by: ____ Your Personal Car Insurance ____ Liability Claim (Another Person's Insurance)

Insurance Company: ________________________________ **Claim #:** ______________________

Adjustor's Name: ____________________________ **Phone # (____) ____-_____ FAX # (____) ____-______**

Claim Mailing Address:____
Street City State Zip Code

If pursuing litigation:

Name of Law Firm : ________________________ **Name of Attorney**: ________________________

Address of Law Firm:____
Street City State Zip Code

Phone # of Law Firm: ( ) _____-_______ **Fax #** ( ) _____-________

Sign: A or B

A) I understand that I and my attorney must agree to the terms of Brookline Physical Therapy's "Letter of Protection/Lien" in order for a liability claim to be considered as a payment source. Patient's Signature:

____

B) I understand that if I am using my personal car insurance I must assign payment benefits to Brookline Physical Therapy and be prepared to pay should I exhaust the medical funds: Patient's Signature:

____

(6) Medical Insurance Information(please provide a copy of Insurance card and complete this section in the event that your Auto or Non-Work Accident claim is denied)

Ins. Co. Name: __________________________ **Ins. Co. Phone #:**_________________________

Insured's Name: __________________________ **Insured is ____Patient ____Spouse ____Parent**

Sex: M F Birthdate: _____/_____/______

Patient ID #: ____________**Group. #** ____________ **Policy/Plan #:** ______________________

Claims Mailing Address: ____
Street City State Zip Code

Employer Name: ____________________________________ **Employer Phone # ( ) ______- _______**

Address: ____ ___________________
Street City State Zip Code

All Patients or Patients' Legal Representative Please Sign Section 9 on Page 3

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(7) Medications : (This includes prescriptions (from your doctor), over the counter drugs, herbal and nutritional supplements)

Separate List Provided Yes No If, No please complete this section

Medication/Drug Name	Dosage	Number of Times Per Day

(8) Payment Authorization: ***(Initials required for all 3 statements)***

_________ **Assignment of Insurance Benefits**

Initials **I authorize that the payment of my insurance benefits be made directly to Brookline Phyiscal Therapy for any services that are reimbursable by my insurance company, if I have one.**

_________ **Guarantee of Payment**

Initials **I understand that all payments designated as 'the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by the billing statement due date.**

_________ **Health Insurance Option** (Copy of Insurance Card Required)

Initials **I agree to Brookline Physical Therapy to file my Health Insurance within the required claims filing period should my Personal Auto or the other party's insurance deny the claim, exhaust the benefits or fail in anyway to pay per the agreed upon terms**

_________ **Certification of Information**

Initials **I certify that the information I have provided Brookline Physical Therapy for payment including, but not limited to,related accidents, illnesses or other insurers is accurate and truthful.**

(9) Signature/ Date:

_______________________________________ _______________

Patient or Legal Representative's Signature **Today's Date**

All Patients or Patients' Legal Representative Please Sign Section 9 on Page 3

PAYMENT AUTHORIZATION

________ **Assignment of Insurance Benefits**

Initials

I authorize that the payment of my insurance benefits be made directly to **Brookline Physical Therapy** for any services that are reimbursable by Medicare, Medicaid or any third party payors.

Guarantee of Payment

I understand that all payments designated as "the patients responsibility" are due and payable at the time of service or billing. I guarantee that I will pay:

________ My designated portion including co-pays/co-insurance and my deductible

Initials

________ All amounts due for services that my insurance company has stated are not covered benefits (**IF** I have been advised by the **Brookline Physical Therap**y in advance of the service delivery and have authorized it in writing)

Initials

________ All amounts due for services billed by **Brookline Physical Therapy** but paid directly to me

Initials

________ All amounts due for services billed by **Brookline Physical Therapy** to a Workers' Compensation payor which was subsequently declared by my employer to be a non-eligible claim.

Initials

________ All amounts due for claims submitted by **Brookline Physical Therapy** to my insurance company and not paid by 60 days

Initials

Medicare and Workers Compensation Information

________ I certify that the information I have provided to **Brookline Physical Therapy** for payment under the Social Security Act (Medicare) or under the Workers Compensation Program is correct, including but not limited to any related accidents/illness or other insurers/payors available.

Initials

I, __________________________, understand the statements I have authorized above and declare their truthfulness

Printed Name

______________________________________ ____________

Patient or Authorized Representative for Patient Signature/Date Initials

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PAYMENT RESPONSIBILITY ACKNOWLEDGEMENT FOR INSURED PATIENTS

Patient Name:____

Insurance Carrier/Company:____

Covered At: _____ % In Network _____ % Out of Network

Covered At: _____/ Visit In Network _____/ Visit Out of Network

Deductible Amount: ______________ Deductible Met: Yes No

Current Patient Balance: _____________________________

Co-Pay or Co-Insurance Due Each Visit:_______

If this is only a portion of what your per visit payment responsibility is you will be billed monthly for the remaining portion.

Please note that Co-Pays are expected at patient sign-in.

If this policy causes a hardship, please see _________________ in our billing office.

_____________________________ _____________________________

Patient Signature/Date Business Office Staff Signature/Date

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PHYSICAL THERAPIST/PATIENT COLLABORATIVE DECISION-MAKING & PLAN OF CARE CHECKLIST

All items listed below must be discussed with the patient by the evaluating therapist <u>prior to</u> treatment initiation. Confirmation of this discuss must be reflected in the evaluation or the initial note confirmed by the patient's signature or documentation of verbal concurrence.

Review physical findings

Review functional findings

Discuss proposed short term plan and expected goals (optional)

Discuss proposed long term plan and expected goals

Rehabilitation potential/prognosis

Rehabilitation diagnosis

Determine frequency and duration of treatment sessions

Discuss precautions and limitations

Discuss alternative and related outcomes

Discuss substantial risks

Obtain verbal or written consent to initiate treatment and plan of care

Sample language to include on the evaluation:

<u>Collaborative Decision Making Statement:</u> The patient and I reviewed his/her clinical and functional status, pros, cons and alternatives of care. We also discussed the plan of care which is outlined above. We conferred about his/her rehabilitation prognosis for improvement/recovery and consent to the plan of care and treatment interventions was obtained.

______________________________ ______________________________

Therapist's signature/date **Patient's signature/date**

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the Notice of Privacy Practices for Brookline Physical Therapy. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Brookline Physical Therapy to release any of my protected healthcare information.

____

Patient's or Authorized Representative's Printed Name & Date

____

Patient's or Authorized Representative's Signature

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HEALTH INFORMATION PRIVACY NOTICE FOR BROOKLINE PHYSICAL THERAPY

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information. Please Review This Document Carefully.

1. <u>About Protected Health Information (PHI).</u>

   In this Notice, “we”, “our” or “us” means this facility and our workforce of employees, contractors and volunteers. “you” and “your” refers to each of our patients who are entitled to a copy of this Notice.

   We are required by federal and state law to protect the privacy of your health information. For example, federal health information privacy regulations require us to protect information about you in the manner that we describe here in this Notice. Certain types of health information may specifically identity you. Because we must protect this health information we call this Protected Health Information---or “PHI”. In this Notice, we tell you about:

   - How we use your PHI
   - When we may disclose your PHI to others
   - Your privacy rights and how to use them
   - Our privacy duties
   - Who to contact for more information or a complaint

2. <u>Some of the ways we use (within the organization) or disclose (outside of the organization) your Protected Health Information</u>

   We will use your PHI to treat you. We will use your PHI and disclose it to get paid for your care and related services. We use or disclose your PHI for certain activities that we call “health care operations”. We will also use or disclose your PHI as required or permitted by law. We will give you examples of each of these to help explain them but space does not permit a complete list of all uses or disclosures. This is one reason why you can contact us and ask us questions.

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Cont. 2. Uses and Disclosures

- <u>Treatment</u>

  We use and disclose your PHI in the course of your treatment. For instance, once we have completed your evaluation or re-evaluation we send a copy or summary of our report to your referring physician. We also maintain records detailing the care and services you receive at our facility so that we can be accurate and consistent in carrying out that care in an optimal manner; that record also assists us in meeting certain legal requirements. These records maybe used and/or disclosed by members of our workforce to assure that proper and optical care is rendered.

- <u>Payment</u>

  After we treat you we will, typically, bill a third party for services you received. We will collect the treatment information and enter the data into our computer and then process a claim either on paper or electronically. The claim form will detail your health problem, what treatments you received and it will include other information such as your social security number, your insurance policy number and other identifying pieces of information. The third party payor may also ask to see the records of your care to make certain that the services were medically necessary. When we use and disclose your information in this way is helps us to get paid for your care and treatment.

- <u>Health Care Operations</u>

  We also use and disclose your PHI in our health care operations. For example our therapists meet periodically to study clinical records to monitor the quality of care at our facility. Your records and PHI could be used in these quality assessments. Sometimes we participate in student internship programs and we use the PHI of real patients to test them on their skills and knowledge. Other operational used may involve business planning and compliance monitoring or even the investigation and resolution of a complaint.

- <u>Special Uses</u>

  We also use or disclose your PHI for purposes that involve your relationship to us as a patient. We may use or disclose your PHI to:

  i. Remind you of appointments
  ii. Carry out follow ups on home programs that you have been taught
  iii. Advise you of new or updated services or home supplies

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Cont 2. Uses and Disclosures

- Uses & Disclosures Required or Permitted by Law

Many laws and regulation apply to us that affect your PHI, they may either require or permit us to use or disclose your PHI. Here is a list from the federal health information privacy regulations describing required or permitted uses and disclosures:

Permitted:

i. If you do not verbally object, we may share some of your PHI with a family member or a friend if he/she is involved in your care
ii. We may use your PHI in an emergency if you are not able to express yourself
iii. If we receive certain assurance that protect your privacy, we may use or disclose your PHI for research

Required:

i. When required by law; for example, when ordered by a court to turn over certain types of your PHI, we must do so
ii. For public health activities such as reporting a communicable disease or reporting an adverse reaction to the Food and Drug Administration
iii. To report neglect, abuse or domestic violence
iv. To the government regulators or its agents to determine whether we comply with applicable rules and regulations
v. In judicial or administrative proceedings such as a response to a valid subpoena
vi. When properly requested by law enforcement officials or other legal requirements such as reporting gun shot wounds
vii. To advert a health hazard or to respond to a threat to public safety such as an imminent crime against another person
viii. Deemed necessary by appropriate military command authorities if you are in the Armed Forces
ix. In connection with certain types of organ donor programs

- Stricter Requirement That We Follow

  We will follow any and all State regulations should they be stricter than these federal privacy regulations

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3. Your Authorization May Be Required

In the situations noted above we have the right to use and disclose your PHI. In some situations, however, we must ask for, and you must agree to give, a written authorization that has specific instructions and limits on our use or disclosure of your PHI. If you change your mind, at a later date, you may revoke your authorization.

4. Your Privacy Rights and How to Exercise Them

You have specific rights under our federally required privacy program. Each of them is summarized below:

- Your Right to Request Limited Use or Disclosure
  You have the right to request that we do not use or disclose your PHI in a particular way. However, we are not required to abide by your request. If we do agree to your request we must abide by the agreement; we have the right to ask for that request to be in writing and we will exercise that right
- Your Right to Confidential Communication
  You have the right to receive confidential communications from us at a location or phone number that you specify. We have the right to ask for that request to be in writing noting the other address or phone number and confirmation that it should not interfere with your method of payment; we will exercise the right to have your request in writing
- Your Right to Inspect and Copy
  You have the right to inspect and copy your PHI. Should we decline we must provide you with a resource person to assist you in the review of our refusal decision. We must respond to your request within thirty (30) days, we may charge reasonable fees for copying and labor time related to copying and we may require an appointment for record inspection; we have the right to ask for your request in writing and will exercise that right.
- Your Right to Revoke Your Authorization
  If you have granted us an authorization to use or disclose your PHI you may revoke at any time it in writing. Please understand that we relied on the authority of your authorization prior to the revocation and used or disclosed your PHI within its scope
- Your Right to Amend Your PHI
  You have a right to request an amendment of your record. We have the right to ask for the request in writing and we will exercise that write. We may deny that request if the record is accurate and/or if the record was not created by this facility. If we accept the amendment we must notify you and make effort to notify others who have the original record

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Cont. 4 Your Privacy Rights and How To Exercise Them

- Your Right to Know Who Else Sees your PHI
  You have the right to request an accounting of certain disclosure that we have made over the past six years; however you may not ask for disclosures that occurred prior to April 14, 2003. We do not have to account for all disclosures, including those made directly to you, those involving treatment, payment, health care operations, those to the family/friend involved with your care and those involving national security. You have the right to request the accounting annually, we have the right to ask for the request in writing and to charge for any accounting requests that occur more than once per year; we must advise you of any charge and you have the right to withdraw your request or to pay to proceed.
- Your Right to Complain
  You have the right to complain if you feel your privacy rights have been violated. You may complain directly to us or to the Secretary of Health and Human Services. We will not retaliate against you if you file a complaint about us. To file a complaint with us please contact the person identified below in this Notice. Your complaint should provide a reasonable amount of specific detail to enable us to investigate your concern.

5. Some of Our Privacy Obligations and How We Perform Them

We are required to comply with the federal health information privacy regulations. Those rules require us to protect your PHI. Those rules also require us to give you Notice of our Privacy Practices. This document is our Notice. If you did not get a paper copy of this Notice, you may request one. We will abide by the privacy practices set forth in this Notice. However, we reserve the right to change this Notice and our Privacy Practices when permitted or required by law.

If we change our Notice of Privacy Practices we will provide our revised Notice to you when you next seek treatment from us.

6. Contact Information

If you have questions about this Notice, or if you have a complaint or concern, please contact:

Name: John Esguerra
Address: 26837 Tanic Drive Suite 101
Wesley Chapel, FL 33544
Phone: (813)527-6913

7. Effective Date: This notice takes effect on April 14, 2003

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