Confidential Medical History

Name: ___________________________ Date: __/__/____ Ordering MD: __________________

Address: _____________________________ City: ____________ State: ____ Zip Code: ______

Date of Birth: __/__/____ Daytime Phone: ________________ Alt Phone: _________________

Email: ______________________________ Sex: M or F Marital Status: S M D Other

Employer: _______________________________ Occupation: ____________________________

Student: Y or N School: _________________________

Is this condition **Work Related** (Y) (N)? **Auto Accident (**Y) (N)?

Please provide a date of **onset/injury/or first contact with MD for this condition:** __________

Have you had Surgery for this condition? ___________________ Date of surgery: ___________

Have you had any diagnostic services for **this** injury? Xrays MRI CT Scan EMG/NCV

Please tell us activities, sports, recreation, or hobbies that are affected by this condition:

____

Names of people in addition to your doctor and insurance company that we may release information to:

____

____

How did you hear about us? (Doctor) (Previous PT) (Friend/Family) (Internet) (Other) _____________

I hearby agree and give my consent to medical treatment for my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible for informing the office of any changes that occur. I authorize release of payment directly to Tompkins Orthopedic Physical Therapy regardless of participation in or out-of-network. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principle amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt.
Interest may be charged at a rate of 1.5% per month (18% annually) for balances over thirty days old.

Patient/Parent/Guardian Signature: ____ Date: _____________

I acknowledge that I have seen the "Notice of Privacy Practices". I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient/Parent/Guardian Signature: ____ Date: _____________

Tompkins Orthopedic Physical Therapy Services, PLC
Billing and Payment Policy

If you have **INSURANCE** we will bill your insurance as a courtesy to you. *If we participate* with your plan, we will collect any co-pay at the time of service. Any deductible, coinsurance or non-covered charges will be due from you upon receipt of the Explanation of Benefits. *If we do not participate* with your plan, all charges not paid in full by your insurance will be due from you upon receipt of the Explanation of Benefits. Prior to your first visit, every effort will be made to verify your insurance benefits. While we take reasonable action to provide accurate physical therapy benefit information for your plan, be aware that verification of benefits is not a guarantee of payment from your insurance carrier. Secondary insurance will be your responsibility to file and collect.

If you have **MEDICARE** we will bill Medicare on your behalf. In most cases, Medicare will pay 80% of their allowable charges. We will bill your secondary insurance for you, if you have it. Otherwise, the balance will be billed to you.

If you are a **SELF PAY** we will expect payment in full at the time of service. In the event you are unable to pay the balance in full, we are willing to make reasonable payment arrangements. Please be advised that failure to maintain the payment arrangements may result in the placement of your account with a collection agency or attorney. Credit cards (MasterCard and Visa) are accepted for payment on account.

If you have **WORKERS' COMP INSURANCE** we will bill your compensation carrier for your charges. Please be advised that you will remain financially responsible for all of your charges if your carrier denies coverage.

If you have a **LEGAL SUIT** we will accept a legal letter of protection if you meet each of the following criteria:

1. You do not qualify for benefits under any insurance policy (medical or auto) and,
2. You are indigent and cannot pay for charges using cash, check, or a credit card, and,
3. You are awaiting settlement and subsequent payment of damages from a related legal case and,
4. We have a lien signed by both you and the attorney representing you in this matter in our possession.

Prior to settlement, payment on your account will not be required unless your charges remain outstanding for more than 90 days from the date of your last treatment. Upon settlement of your legal case, payment in full is due within 30 days.

Please be aware that you will remain financially responsible for services rendered regardless of the category that applies to you. In the event your account becomes delinquent and is in default of payment, the patient, legal guardian, or admitting parent will be responsible for the principal amount owing, and all reasonable costs associated with the collection of this debt, including, but not limited to, collection service fees, attorney's fees, and all court costs and additional legal expenses associated with the recovery of this debt. We reserve the right to charge interest on balances over 30 days old, charge for returned checks, and no show fees for missed appointments when adequate notice of cancellation is not provided.

If you have any questions regarding the above, please feel free to ask for assistance. Please sign and date this document to indicate that you understand and agree to the terms of our payment policy.

SIGNATURE ____ DATE ______________

PROVIDER 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.

Uses and disclosures of health information:
We use health information about your treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Continuity of care is part of treatment and your records may be shared with other providers who are treating you or to whom you are referred. Information may be shared by paper mail, electronic form, fax, or other methods.

We may use or disclose identifiable health information about you without your authorization for several reasons. Subject to certain requirements, we may give out health information without your authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances, and to respond to lawsuits and legal actions. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

Individual Rights:
In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. You may request a copy of your health information in an electronic form. However, if you request a paper copy, we will charge you normal photocopy fees. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment or related administrative purposes and other than when you explicitly authorized it. You can request us not to share certain health information for treatment, payment or operations. However, we are not required to agree to your request. You may restrict disclosures to a health plan regarding treatment that you paid out of pocket in full. You can ask us to correct health information that you believe is incorrect or incomplete. We may decline your request, but we will advise you why in writing within 60 days of your request. You can request confidential communications (for example which phone number to use for confidential messages from us, or that you prefer emails). We never share your information for marketing without your written permission, nor do we ever sell your information.

Complaints:
If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also file a complaint in writing to the U.S. Dept. of Health and Human Services Office for Civil Rights at 200 Independence Ave, SW, Washington, DC. 20201, by calling 877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Our Legal Duty:
We are required by law to protect the privacy of your information, provide this notice about our information practices, follow the information practices that are described in this notice, and obtain your acknowledgement of receipt of this notice.

If you have any questions or complaints, please contact:
Pam Coats, Business Director
22 Fairfax Street, SE
Leesburg, VA 20175
Phone: 703-669-6100