

SPORTS THERAPY CENTER

PATIENT MASTER FILE

GENDER: () MALE () FEMALE

FIRST NAME: _____ MIDDLE INTL: _____ LAST NAME: _____

ADDRESS: _____
(Street or P.O. Box) (City) (State) (Zip)

HOME PHONE: (____) _____ CELL PHONE: (____) _____

E-MAIL ADDRESS: _____ TEXT MESSAGE, OK? Y () N ()

BIRTHDATE: _____ AGE: ____ SOC. SEC #: _____ - _____ - _____ MARITAL STATUS: M () S ()

EMPLOYER: _____ WORK PHONE: (____) _____

EMERGENCY PHONE: (____) _____ CONTACT: _____

REFERRING PHYSICIAN: _____ DIAGNOSIS: _____

DATE OF INJURY: _____ WAS THE INJURY: () JOB RELATED () AUTO () OTHER

HAVE YOU HAD ANY PREVIOUS THERAPY RELATED TO YOUR PRESENT INJURY? Y () N ()

HAVE YOU HAD ANY HOME HEALTH RELATED TO YOUR PRESENT INJURY? Y () N ()

WHOM MAY WE THANK FOR YOUR REFERRAL? _____

IF THE PATIENT IS NOT THE SUBSCRIBER, ENTER THE FOLLOWING INFORMATION ABOUT THE SUBSCRIBER:

FIRST NAME: _____ MIDDLE INTL: _____ LAST NAME: _____

ADDRESS: _____

EMPLOYER: _____

HOME PHONE: (____) _____ CELL PHONE: (____) _____

WORK PHONE: (____) _____ BIRTHDATE: _____

SOC. SEC. #: _____ - _____ - _____ RELATION TO PATIENT: _____

INSURANCE ASSIGNMENT AND CONSENT TO TREAT: Please read and sign

- (1) I authorize the employees of Sports Therapy Center to render routine and emergency physical/occupational therapy services, issue durable medical equipment and any other services required and prescribed by my attending physician.
- (2) I hereby assign to Sports Therapy Center all payments for medical services rendered to myself, or my dependents when applicable. I further assign and transfer to Sports Therapy Center an interest in any cause of action I may have arising out of injuries directly or indirectly resulting in this period of care. This assignment includes insurance benefits accruing to me under uninsured motorist coverage.
- (3) If a Medicare Patient, I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment or approved benefits be made directly to Sports Therapy Center on my behalf. In the event that services were determined by Medicare not to be medically reasonable and necessary and the entire bill is paid under the waiver of liability provision, I will allow Sports Therapy Center to re-open my claim for medical review on my behalf.
- (4) I hereby authorize Sports Therapy Center to treat my minor child.

I have read and fully understand the above information.

PATIENT'S SIGNATURE: _____

PARENT'S SIGNATURE: _____

(Applies only if patient is a minor child)

DATE OF SIGNATURE: _____

PLEASE DO NOT STAPLE IN THIS AREA

HEALTH INSURANCE CLAIM FORM

Form with multiple sections: 1. MEDICARE/MEDICAID/CHAMPUS/CHAMPVA/GROUP HEALTH PLAN/FECA BLK LUNG/OTHER; 2. PATIENT'S NAME; 3. PATIENT'S BIRTH DATE; 4. INSURED'S NAME; 5. PATIENT'S ADDRESS; 6. PATIENT RELATIONSHIP TO INSURED; 7. INSURED'S ADDRESS; 8. PATIENT STATUS; 9. OTHER INSURED'S NAME; 10. IS PATIENT'S CONDITION RELATED TO; 11. INSURED'S POLICY GROUP OR FECA NUMBER; 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE; 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE; 14. DATE OF CURRENT ILLNESS; 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS; 16. DATES PATIENT UNABLE TO WORK; 17. NAME OF REFERRING PHYSICIAN; 18. HOSPITALIZATION DATES; 19. RESERVED FOR LOCAL USE; 20. OUTSIDE LAB?; 21. DIAGNOSIS OR NATURE OF ILLNESS; 22. MEDICAID RESUBMISSION CODE; 23. PRIOR AUTHORIZATION NUMBER; 24. TABLE with columns A-K; 25. FEDERAL TAX I.D. NUMBER; 26. PATIENT'S ACCOUNT NO.; 27. ACCEPT ASSIGNMENT?; 28. TOTAL CHARGE; 29. AMOUNT PAID; 30. BALANCE DUE; 31. SIGNATURE OF PHYSICIAN OR SUPPLIER; 32. NAME AND ADDRESS OF FACILITY; 33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #.

CARRIER PATIENT AND INSURED INFORMATION FOLD HERE FOR PROPER ENVELOPE POSITIONING PHYSICIAN OR SUPPLIER INFORMATION

FOLD HERE FOR PROPER ENVELOPE POSITIONING

SIGNED

DATE

SIGNED



2225 Williams Trace Blvd.

Suite 104

Sugar Land, Texas 77478

281-980-5444

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care, and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- All patients must complete and sign our "Patient Information Forms" before being treated.

UNACCOMPANIED MINORS

Unaccompanied minors cannot receive treatment unless patient information forms have been signed by the parent/guardian prior to the first visit. Parents/guardians are responsible for payment.

- A PAYMENT IS EXPECTED AT EACH TIME OF SERVICE TO APPLY TOWARD YOUR DEDUCTIBLE, CO-INSURANCE, OR CO-PAYMENT AS APPLICABLE.
- WE ACCEPT CASH, CHECK, DISCOVER, VISA/MASTERCARD.

REGARDING INSURANCE

As a service to our patients, we will file with your insurance company. However, you are still responsible for payment of all services.

We will accept insurance on the first visit provided insurance benefits can be verified prior to the scheduled appointment or at the time of service. If this cannot be done, full payment will be required at the time of service.

CONTINUED ON BACK

You are responsible for any deductible, coinsurance, and co-pay amounts, which are not covered by your insurance. If your insurance company pays more than the balance due, we will send a refund check to you when all outstanding claims have been processed.

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY.

We are NOT a party to this contract in some cases. We will inform you if we are a party to your insurance contract, and will handle your claims according to our agreement with the insurance company, if one exists. We will supply factual information to assist you should a dispute arise between you and your insurance company.

MEDICARE

Although we participate with Medicare, you are still responsible for 20% of Medicare allowable as well as deductible and non-covered services. As a courtesy to our Medicare patients, we will file with your secondary insurance. However, secondary insurance does not pick up what Medicare disallows.

WORKERS COMP

We will file on Worker's Compensation claims, however we must be able to obtain authorization from your adjuster prior to the scheduled appointment.

PIP/ MOTOR VEHICLE ACCIDENTS

For automobile accidents, we will file with your PIP Auto Insurance or your Health Insurance with prior approval. You are always responsible for outstanding charges that your insurance company denies.

Please sign below indicating your understanding of our FINANCIAL POLICY.

Responsible Party Signature

Date

Rehab Resources of America

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Rehab Resources of America's LEGAL DUTY

Rehab Resources of America is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Rehab Resources of America uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Rehab Resources of America may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Rehab Resources of America may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Rehab Resources of America's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Rehab Resources of America may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Rehab Resources of America will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Rehab Resources of America may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Rehab Resources of America's health information practices or if you have a complaint, please contact the following person:

Rehab Resources of America, Inc.
Leanne Pfister, Administrator
2225 Williams Trace Boulevard, Suite 104
Sugar Land, Texas 77478
Telephone: 281-980-299 Fax: 281-980-0142

Rehab Resources of America
PATIENT INFORMATION CONSENT FORM

I have read and fully understand Rehab Resource 's Notice of Information Practices. I understand that Rehab Resources may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Rehab Resources will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Rehab Resource's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Signature

Date