OrthoSportsMED™
Physical Therapy

New Patient Information Sheet

Date: _____

Name: _____ DOB: _____

Phone: H: _____ Cell: _____

Home Address: _____

Email: _____

Emergency Contact: Name: _____

Phone: _____ Relationship: _____

Insurance Company: _____ HMO PPO POS

Who is the primary subscriber on the insurance? _____

Primary subscriber date of birth: _____

Referring physician (indicate if PCP):_____

Address: _____

Phone: _____ Fax: _____

Please provide your PCP information:

Name: _____

Address: _____

Phone: _____ Fax: _____

Consent for Treatment

I, the undersigned, a patient at OrthoSportsMED™ Physical Therapy (OSMPT)*, do hereby authorize Kipp K. Dye, MSPT, or any of the licensed physical therapy staff to administer treatment as necessary. I also certify that no guarantee or assurance has been made to the results that may be obtained.

I understand and agree that health and accident insurance policies are an arrangement between as insurance carrier and myself. Furthermore, I understand that OSMPT will prepare insurance forms, and will bill only as a courtesy my insurance company directly. **However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.**

Timely Payments Required

PATIENTS WITH DELINQUENT BILLS WILL BE CHARGED A DELINQUENT BILLING FEE OF $25.00

Deductibles/Percentage pays and/or Co-Payments

Co-payments are to be paid AT TIME OF SERVICE, unless prior arrangements have been made with the Office Manager. Deductible and percentage payment amounts will be billed at the time the payment from your insurance company is received. Payment is due within 15 days of the date on the invoice. Patients are to keep payments current.

Cancellation/No-Show Policy

I understand that cancellations should be made the day prior to the day of my scheduled appointment(s), unless extenuating circumstances prevent otherwise. The fee for no-shows is $25.00. NOTE: Appointments will be classified a no-show if cancellations are made the same day of my scheduled appointment(s).

By signing below you are agreeing to all the above terms and conditions.

_____ _____

Patient or Legal Guardian's Signature Date

Previous Physical Therapy Treatment Information

Patient Name: _____

1. Have you been treated for the same body part in the past year? Also include treatment from prior years. (Example: Right ankle)

_____

_____

2. What was the exact diagnosis? (Example: Right Achilles Tendonitis)

_____

_____

3. Do you have any supporting documents from that physical therapy treatment? (Example: MD prescription, MRI, etc.)

_____

_____

4. How many visits did you have?

_____

_____

5. What was the date range of those visits?

_____

_____

OrthoSportsMED™
Physical Therapy

Medical History Form

Name: _____ Date of Injury: _____

Chief Complaint

Why are you seeing the physical therapist today? _____
_____

Current problem is the result of a (n): Check all that apply:

□ Car Accident □ Work Accident □ Injury □ Other _____

Please list any significant medical conditions in your past medical history:

_____
_____

Surgeries	**Year**	**Complications**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications	**Dose**	**How Long?**	**Side Effects**
_____	_____	_____	_____
_____	_____	_____	_____

Please list any allergies: _____
_____

Functional Profile

Exercise? □Daily □Weekly □Monthly □Rarely □Never
What does your job entail/require functionally? _____
_____

Patient/Patients Guardian Signature: _____

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of OrthoSportsMED™ Physical Therapy notice of Privacy Practices.

Patient name (please print)

Signature

Date (mm/dd/yyyy)

Notice of Privacy Practices
Effective September 15, 2003

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.

UNDERSTANDING THE TYPE OF INFORMATION WE HAVE

We receive information about you during your first visit with us, including your name, date of birth, gender, ways to contact you, your social security number, financial information, insurance information and other personal information. We also collect information regarding your condition, diagnosis and treatment. Along with collecting this information from you, we also get enrollment and eligibility status from your health insurer and medical information from other health care providers.

OUR PRIVACY COMMITMENT TO YOU

The information we collect about you is private. We are required to give you an idea of our privacy practices. Only those individuals who have both the need and the legal right may view your information. Unless you give us permission in writing, we will only disclose your information for purposes of treatment, payment, business operations, and when we are required by law to do so, or for one of the other reasons listed below.

- Treatment: We may use or disclose medical information about you to provide and coordinate your health care. For example, after you initial appointment with us we usually send a letter to you referring physician regarding your treatment. Another letter shall be sent after you have been discharged from our care.
- Payment: Information may be disclosed so that the care you get receive can be properly billed and paid for. For example, we may send your health insurer a bill for our services explaining the treatment you received and why.
- Business Operations: We may need to use and disclose information in our business operations. For example, in order to improve activity necessary to run the business (training or for reviewing the quality of care that you and others receive from us).
- Exceptions: For certain kinds of records, your permission may be required, even for release of treatment, payment and business operations. We will provide you with authorization and consent forms for your signature in order for us to release certain information
- Phone Messages: We may contact you via phone, answering machine or mail to provide you with authorization, referral, and billing information including information regarding other services that may be of interest to you. You may request in writing if you do not wish for this information to be left with a person other than yourself via phone.

- As required by Law and for other Government Functions: We will release information when required to do so by law or for other government functions, examples of such

releases would be for law enforcement, subpoenas or other court orders, for national security purposes, communicable disease reporting, disaster relief, review of our activities by government agencies, to avert a serious threat to health or safety or in other kinds of emergencies.

- Public Health and Safety: We may use or disclose information about you as necessary to prevent or reduce a serious threat to the health or safety of another person or the public. For example, we will have to disclose information about certain diseases (and immunizations) to public health officials.
- Family and Friends: We may disclose your information to family members, friends or others you identify to the extent it is relevant to their involvement with your care or payment for your care, or to let them know about where you are and your condition.
- After Death: We may disclose your information to coroners or medical examiners and funeral homes after you are deceased.
- With Your Permission: If you provide us permission in writing, we may use and disclose you personal information for the purposes you list. If you give us permission, you have the right to change your mind and revoke it, but this must be in writing. We cannot take back any uses or discloses already made with you permission.

Our use and disclosure of your personal health information must comply not only with federal privacy regulations but also with applicable Massachusetts's law. Massachusetts's law provides different protection to your personal health information. For example, Massachusetts provides extra protection for minors; we must adhere to the more stringent state privacy protections.

PATIENT RIGHTS

You have the following rights regarding the health information we have about you. Your requests must be made in writing to us at:

OrthoSportsMED™ Physical Therapy
PO Box 920370
Needham, MA 02492

We are committed to ensuring that you receive information regarding your rights as a patient here at OrthoSportsMED™ Physical Therapy.

- Your Right to Inspect and Copy: In most cases, you have the right to look at or receive copies of your medical records upon signing a Medical Record Release form, and in some cases paying a fee if we need to retrieve such records from storage. Please call ahead to ensure that we have your records available for you.
- Your Right to Amend: You may request us to modify your records if you feel the records are not correct. We may deny your request for certain reasons, but we must provide in writing to you the reason for our denial.
- Your Right to a List of Disclosures: You have the right to ask for a list of certain disclosures made after September 15, 2003. This list will include the times that information was disclosed for treatment, payment, or health care operations. The list will include information provided directly to you or your family, or information that was sent with your permission. It will include information released without your name or other date that would identify you.

- Your Right to Request Restrictions on Our Use or Disclosure of Information: You can ask for limits on how your information is used or disclosed. We are not required to agree to such a request, but may if we believe it is reasonable to do so.

- Your Right to Request Confidential Communications: You have the right to ask that we share information with you in a certain way or in a certain place. For example, you may ask us to send information to your college address instead of your home address or you may ask that we treat you in a room other than the main treatment area. We will do our best to accommodate such a request.

CHANGES IN THIS NOTICE

We reserve the right to revise this notice. A revised notice will be effective for medical information we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever notice is currently in effect. If the changes are material, a new notice with be posted.

HOW TO USE THES RIGHTS UNDER THIS NOTICE

If you want o exercise your rights under this notice or have any questions regarding our privacy issues, you may call or write to us at:

OrthoSportsMED™ Physical Therapy
PO Box 920370
Needham, MA 02492

Or call the administrative office at:

(781) 444-1290

Complaints to us if you believe that your privacy rights have been violated or you wish to express your concern regarding non-compliance of our privacy policies and procedures; you may file a complaint by writing to the above address. We will require a written complaint, and may further provide you with an official complaint form that you would need to fill out for our records. You will not be penalized for filing a complaint.

ADDITIONAL INFORMATION

HIPAA is the Health Insurance Portability and Accountability Act of 1996. The revised and updated Privacy Rule portion of HIPAA, including many of the policies described in this notice, went into effect September 15, 2003. You may further research the policies and guidelines of HIPPA via the internet. We will also keep a copy of the final Standards for Privacy of Individually Identifiable Health Information at our front desk for patients to view at their leisure.

A copy of this Notice of Privacy Policies will be posted at each of our offices. You will need to read and acknowledge (via signature) that you have received these privacy policies and procedures. A copy of this acknowledgement will be filed in our office.

Insurance Coverage and Patient Responsibility

Please note that as a patient of OrthoSportsMED™ Physical Therapy, you are responsible for payment of all health care services provided to you. Therefore, it is incumbent upon you to understand to what extent your insurance provider will cover such services. Insurance plans differ in coverage, and as a result the amount of your responsibility.

Some plans have co-payments, co-insurance or deductibles, while others have a combination of these. There are also restrictions on the number of visits permitted by the various plans. It is your responsibility to understand the requirements of your particular plan. We will work with you to clarify any questions that we are able.

Any visits that are not covered under your insurance plan will be billed to you at our discounted private pay rate of $80 for a follow-up visit and $110 for an evaluation.

Any co-payments that you do not pay up front will be billed at the end of each month by our Corporate Office.

Any other payments, such as co-insurances, deductibles, or uncovered visits, will be billed out by OrthoSportsMED™ Physical Therapy internally. This will be done after Dunn Professional Billing receives your Explanation of Benefits (EOB) from your insurance company.

If you disagree with any bills that you are receiving contact the Member Services department of your insurance company. The number should be located on your insurance card. Also, refer to any claim information that you receive regarding these services.

Any other billing questions should be directed to:
OrthoSportsMD™ PT Billing Dept.
Marina Trapezina, Office Manager
Marinat@osmed.net
(781) 444-1290

All payments should be sent to:
OrthoSportsMED™ PT
1237 Highland Ave.
Needham, MA 02492

Thank you in advance,
OrthoSportsMED™ Physical Therapy

By signing below you are agreeing to all the above terms and conditions.

_____ _____

Patient or Legal Guardian's Signature Date

1237 Highland Avenue
Needham, MA 02492
(781) 444-1290
(866) 305-1388 fax

To our Valued Patients:

At OrthoSportsMD™ we are always looking for ways to make our patients' healing experience hassle-free. We currently bill for patient services to ensure the utmost ease and accuracy for the ultimate goal of high quality service to our patients.

With that type of service in mind you will have noticed that we began implementing a collection system for co-pays at the time of your treatment. Beginning this month we will add the ability of you to utilize credit cards to pay for your co-pay, coinsurance, or deductible. To handle the payment of co-pays most efficiently we will begin a system of processing co-pays on a weekly basis, with the payment processing on the Wednesday following your treatments.

Enclosed with this letter you will find a credit card authorization form along with a pre-addressed envelope for your convenience. We hope that you will find this new feature of Orthosports beneficial. If you have any questions or concerns, please feel free to call. We thank you for your continued business.

If you have any questions regarding the charges on your credit card please call our Office Manager at our Corporate Headquarters in Needham. The phone number is (781)-444-1290.

OrthoSportsMED™
Physical Therapy

Credit Card Authorization

I authorize Orthosports & Aquatic Physical Therapy, P.C. to charge my credit card for therapy services rendered. My authorized signature on this form will be valid for any future, ongoing charges for co-payments; co-insurances, or charges rejected by my primary insurance carrier. **I am aware and authorize the charge of a $25 fee for any "No Show" or "Cancel w/Out Notice" (appointments not cancelled prior to the scheduled appointment day) appointments unless in case of an emergency.** I further understand that Orthosports' **Notice of Insurance Coverage & Patient Responsibility** is incorporated with this authorization and made apart hereof. Orthosports will charge my credit card on its regularly scheduled billing cycle, which may be as often as once a week.

Patient Name (please print):	Date:	
Email Address:	Phone Number:	
Billing Address:		
City:	State:	Zip:
Name as it appears on the credit card (if different than above):		
Select type of card: ❑ Visa ❑ MasterCard ❑ Discover ❑ American Express		
Card number:	Verification #:	Exp. Date:
I promise to pay fees as noted above subject to and in accordance with the agreement Governing the use of such card.		
Signature of Cardholder:		

By signing this form, you authorize Orthosports & Aquatic Physical Therapy, P.C. to keep your credit card number on file and bill all future visits directly to your credit card.