Date: _____ Primary Insurance: _____ Secondary or Supplement: _____

Patient Information (Please Print):

Full Name: _____Home Phone (____) _____Cell Phone: _____

Address: _____City: _____ State: _____ Zip: _____

Mailing Address (if different):_____City: _____ State: _____ Zip: _____

Date of Birth: _____ SSN: _____ Single: _____ Married: _____ Student: _____

E-Mail Address: _____

Employer: _____ Phone: _____ Job Title: _____

Address: _____ City: _____ State: _____ Zip: _____

Person Responsible for Payments (such as, co-payment, co-insurance or deductible)

Name: _____ Relationship to Patient: _____ Date of Birth: _____

Mailing Address: _____ City/State: _____ Zip: _____ Phone: _____

Referring Physician

Physician: _____ Phone: _____ Fax: _____

Address/Practice: _____ City/State: _____ Zip: _____

Is the condition for which you are receiving physical therapy related to a Motor Vehicle Accident or a Workers Compensation Injury?

Yes: _____ No: _____ If yes, what was the Date of Accident or Injury: _____ State Occurred: _____

Name of Insurance Company handling your claim: _____ Claim Number: _____

Address: _____ City/State: _____ Zip Code: _____

Claim Representative: _____ Phone: _____ Fax: _____

Medical History

Please list current medication including vitamins and over-the-counter medications, including dosages and frequency.

_____

_____

Surgeries (recent and/or pertinent): _____

Allergies: _____

Do you smoke? Yes/No

Do you have any of these medical conditions? *(Please circle any that apply)*

Cardiac Condition Diabetes Asthma Cancer High Blood Pressure Pregnancy

Do you experience unsteadiness or loss of balance while walking? _____ Have you fallen in the past year? _____

If yes, how many times? _____ Do you experience dizziness? _____ If yes, what treatment was rendered? _____

Primary Care Physician Referrals

If your insurance coverage is an HMO plan, requiring authorization for treatment from your Primary Care Physician (PCP), we will assist you in maintaining a current treatment authorization; however, you must be aware that it is primarily your responsibility to know the limits on duration of treatment that your PCP has authorized and to work with your physician's office in obtaining extensions, should they be necessary, on authorizations that may expire during the course of treatment.

Insurance Billing

As a courtesy to our patients we will submit all claims for your treatment to your insurance carrier(s). We will make every effort to verify your insurance coverage and notify you of any deductible and/or estimated co-payment or co-insurance amounts, for which you are responsible on each date of service.

Insurance Coverage

It will be the patient's responsibility to notify our office of any changes in their insurance coverage during the course of treatment. If for any reason your coverage/carrier changes and you neglect to notify us, any charges not covered due to lack of notification will be your responsibility.

Attorney Liens

It is the policy of this clinic NOT to accept attorney liens in the case of auto mobile accidents or other injuries involving litigation. In most cases your own health insurance will cover your treatment.

Returned Check Fee

There will be a $25.00 fee for any check returned unpayable.

Collection Fees

If your account is forwarded to the collection agency, you will be responsible for the balance owed at the time it is forwarded plus any fees charged by the agency, which can range from 33% - 55% of your outstanding balance.

Payment for Minor

When the patient is a minor dependent of divorced parents, the parent accompanying the child to the appointment will be responsible for the payment of any balance, co-payment, and co-insurance or deductible.

If you have any questions or concerns regarding any of the above policy, please feel free to discuss with our office staff.

I have read the above statements and fully understand the policies of **Rochester Physical Therapy LLC dba Orthopedic & Sport Therapy Services** regarding insurance claims and my responsibilities regarding physician's referrals, insurance coverage and billing, attorney liens, fees and payment of any balance owed. My signature acknowledges I agree to the terms of this statement regarding payment for services and authorize **Rochester Physical Therapy LLC dba Orthopedic & Sport Therapy Services** to treat the named patient.

Signed: _____Date:_____

We have been informed by your health insurance carrier your benefits for treatment are as follows:

(This information was given to us by your insurance company and is not a guarantee of payment or benefits by your insurance company.)

----------The section below to be completed by OSTS----------

1. Calendar year deductible $_____ of which $_____ has been met, leaving a remaining deductible due of $_____.

   After this deductible has been satisfied, the remaining charges will be processed at _____ %. Therefore, the co-insurance for which you are responsible to pay will be approximately _____% per visit.

2. Your Insurance requires no deductible. Your co-pay responsibility for each visit is $_____

3. Your Insurance allows for _____ therapy visits per calendar year/ policy year. Authorization Required: Yes No

4. If you have a Secondary Insurance or a Medicare Supplemental Plan we will bill both insurances.

Primary Medical Insurance

Insured Person Name (Policy Holder): _____ Phone: _____

Address: _____ City/State: _____ Zip: _____

Date of Birth: ___/____/_____ Employer: _____ *Relationship to Patient: Self_____ Spouse_____ Parent_____

THIS SPACE RESERVED FOR COPY OF INSURANCE CARD

Secondary or Supplemental Insurance

Insured Person Name (Policy Holder): _____ Phone: _____

Address: _____City/State: _____ Zip: _____

Date of Birth: ___/____/_____ Employer: _____ *Relationship to Patient: Self_____ Spouse_____ Parent_____

THIS SPACE RESERVED FOR COPY OF INSURANCE CARD

_____Please Sign Below_____

I authorize the release of any medical or other information necessary to process this claim.

Patient, Parent or Guardian Signature: _____ Date: _____

I authorize payment of medical benefits to Orthopedic and Sport Therapy Services for physical therapy services provided to patient.

Patient, Parent or Guardian Signature: _____ Date: _____

Rochester Physical Therapy LLC dba Orthopedic & Sport Therapy Services

Authorization

If you would like to allow a friend or family member to speak with us regarding your treatment, scheduling of appointments or payments, please confirm your request by completing the section below, including your signature and the date.

I hereby authorize one or all the designated parties below to request and receive the release of any protected health information regarding my treatment, payments and administrative operations including the scheduling of appointments. I understand the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name: _____

Patient/Parent Signature: _____

Date: _____

Contact Information

Why did you choose OSTS? (Circle one) -PCP -Specialist -Internet search -Prior patient -Family/Friend -Other:_____

What is the best number to reach you at? Home Cell

May we leave a message with anyone who answers the phone? Yes No

May we leave a voicemail message if necessary? Yes No

We offer a text message, email or call appointment reminders. If you wish to receive a reminder, please select **one** option below and provide the email or phone number we should use.

A) For text message - Cell phone number: _____
B) Email reminder – Email address: _____
C) Automated phone call reminder – Phone number: _____

(Please understand this is done as a courtesy only and there is no guarantee of receiving reminders. Please do not rely solely on these reminders for your appointment.)

Signed: _____ Date: _____

Rochester Physical Therapy LLC dba Orthopedic and Sport Therapy Services

Cancellation and Missed Appointment Policies

CANCELLATION POLICY

Rochester Physical Therapy LLC dba Orthopedic & Sport Therapy Services is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent other patients from being seen.

Please call us at 603-330-3337 - 24 HOURS prior to your scheduled appointment, to notify us of any changes or cancellations. To cancel a **Monday** appointment, please call our office on the **Friday** before, prior to the time you are scheduled to be seen on Monday.

Example: Appointment is scheduled for 2 p.m. on Wednesday, we will need to hear from you prior to 2 p.m. Tuesday.
With regard to a Monday appointment, if the appointment is scheduled at 11 a.m., we will need to hear from you prior to 11 a.m. on Friday.

We make every effort to accommodate ALL our patients. We appreciate your compliance with this policy.

If timely, prior notification is not given, you may be charged $25.00* for the cancelled appointment and your therapist will consider discontinuing your treatment.

MISSED APPOINTMENT POLICY

If you miss your appointment, any future appointments will be removed from our treatment schedule and you will be charged $25.00 for the missed appointment.

We will reschedule your missed appointment after you have contacted our office. In addition, you may be limited to scheduling only one appointment at a time going forward.

If you miss any future appointments, your therapist may consider discontinuing your treatment.

*Please note the $25.00 cannot be billed to your insurance company.

I have read the above statements and fully understand the policies of Rochester Physical Therapy LLC dba Orthopedic and Sport Therapy Services regarding my responsibilities relating to Cancelled and Missed Appointments.

My signature acknowledges I agree to the terms of this statement regarding payment for missed or cancelled appointments.

Signed: _____ Date: _____

Rochester Physical Therapy dba Orthopedic & Sport Therapy Services

OSTS

Notice of Patient Information 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.

LEGAL DUTY OF ORTHOPEDIC AND SPORT THERAPY SERVICES

Rochester Physical Therapy LLC dba Orthopedic & Sport Therapy Services 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 described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Rochester Physical Therapy LLC dba Orthopedic & Sport Therapy Services uses your personal health information for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care we provide. For example, Rochester Physical Therapy LLC dba Orthopedic & Sport Therapy Services, 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. Also, when treating Workers' Compensation Patients, Rochester Physical Therapy LLC dba Orthopedic & Sport Therapy Services may disclose information to employers as part of work modification or return to work planning.

Rochester Physical Therapy LLC dba Orthopedic & Sport Therapy Services 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 it is the policy of Rochester Physical Therapy LLC dba Orthopedic & Sport Therapy Services 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 further disclosures at any time.

Rochester Physical Therapy LLC dba Orthopedic & Sport Therapy Services 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 treatment 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.

PATIENTS 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 we correct any inaccurate or incomplete information in your records. You also have the right to request a list of the 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. Rochester Physical Therapy LLC dba Orthopedic & Sport Therapy Services will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CLINIC DESIGN

The physical clinic space at Rochester Physical Therapy LLC dba Orthopedic & Sport Therapy Services utilizes curtained treatment cubicles and an open gym area. Every effort will be made by the professional and clerical staff of Rochester Physical Therapy LLC d/b/a Orthopedic & Sport Therapy Services to protect your personal health information, but there may be times when other patient or someone other than the professional and clerical staff of Rochester Physical Therapy LLC d/b/a Orthopedic & Sport Therapy Services, may hear or see your information.

Also, it should be noted, as you fill out the required paperwork in our waiting room, the possibility exists someone other than the professional and administrative staff of Rochester Physical Therapy LLC dba Orthopedic & Sport Therapy Services could look at your paperwork while you are

completing it. Again, every effort by the professional and administrative staff of Rochester Physical Therapy LLC dba Orthopedic & Sport Therapy Services will be made to prevent this from occurring.

CONCERNS AND COMPLAINTS

If you are concerned that Rochester Physical Therapy LLC dba Orthopedic & Sport Therapy Services 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 Director of Treatment 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 the health information practices of Rochester Physical Therapy LLC dba Orthopedic & Sport Therapy Services or if you have a complaint, please contact the following person:

Patrick O'Donnell

Rochester Physical Therapy LLC dba Orthopedic & Sport Therapy Services

393 Gonic Road

Rochester, New Hampshire 03839

Telephone: 603-330-3337

Fax: 603-330-3387

PATIENT INFORMATION ACKNOWLEDGEMENT

I have read and fully understand the Notice of Patient Information Practices of Rochester Physical Therapy LLC dba Orthopedic & Sport Therapy Services. I understand Rochester Physical Therapy LLC dba Orthopedic & Sport Therapy Services may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluation the quality of services provided, and any administrative operations related to treatment or payment. I understand I have the right to restrict how my personal health information is used and Rochester Physical Therapy LLC dba Orthopedic & Sport Therapy Services 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 the Notice of Patient Information Practices of Rochester Physical Therapy LLC dba Orthopedic & Sport Therapy Services. I understand I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name (printed) _____

Patient/Parent Signature _____

Date _____