PATIENT INFORMATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient Name (Last, First MI)	Date of Birth ___/___/___	Age	Marital Status S M W D	Today's Date ___/___/___
Address (Street – City – State – Zip)	Home Phone (_____) _____-______		Work Phone (_____) _____-______	
Employer Name	Cell Phone (_____) _____-______		Social Security No.	
Employer Address (Street – City – State – Zip)	Sex M___ Fe___	Date of Injury ___/___/___	Workers Comp ____ Auto ____ Other ____	
Spouse's Name (Last, First, MI)	DOB ___/___/___	Social Security No.	Spouse's Work Phone (_____) _____-______	
Nearest friend not living with you	Address (Street – City – State – Zip)		Home Phone (_____) _____-______	
Nearest relative not living with you	Address (Street – City – State – Zip)		Home Phone (_____) _____-______	
Emergency Contact	Relationship		Phone (_____) _____-______	

Are you currently being treated by a home health agency? ______ Is injury related to an Auto accident? ______

How did you hear about us? Please circle: Internet Postcard Phone Book Billboard Newspaper Ad Newsletter Health Fair Seminar

Other: ________________________________(physician, family friend, adjustor, previous patient, etc.)

Name of Referring Physician: Name of Family Doctor:

Who is financially responsible for this bill?

How will the bill be paid today?

INSURANCE INFORMATION

Primary Insurance Name	Phone (_____) _____-______		Address (Street – City – State – Zip)
Name of Insured	Relationship	I.D. No.	Group No.
Secondary Insurance Name	Phone (_____) _____-______		Address (Street – City – State – Zip)
Name of Insured	Relationship	I.D. No.	Group No.
Attorney Name (if applicable)	Phone (_____) _____-______		Address (Street – City – State – Zip)

I acknowledge that the above information is true and correct. I hereby authorize treatment and understand the possible benefits and risk of my treatment. I know and agree that ISR Physical Therapy, LLC is not responsible for loss or damage to personal items. I irrevocably assign all benefits directly to ISR Physical Therapy, LLC. I authorize release of any medical records necessary to process medical claims. I understand that I am fully responsible for any and all costs incurred for services rendered as well as any costs not paid by my insurance company or financially responsible party and /or costs incurred for collection on my account.

Patient Signature: ____________________________ Date: ________________________

Guarantor Signature: ____________________________ Date: ________________________
(if under 18)

Email Address: ____

Would you like to receive monthly newsletters from ISR Physical Therapy via email? ___Yes ___No

ASSIGNMENT OF BENEFITS

ISR Physical Therapy of Houma
478 Corporate Drive
Houma, LA 70360
(985) 872-5911   Fax (985) 872-6155

Date_______________________

Patient:_______________________________________

Employer:_____________________________________

Claim/Group No._______________________________

SS No./ID No.__________________________________

I hereby instruct and direct ____________________________ insurance company to pay by check made out and mailed to:

I.S.R. Physical Therapy of Houma
478 Corporate Drive
Houma, LA 70360
(985) 872-5911   Fax (985) 872-6155

If my current policy prohibits direct payment to the provider, I hereby also instruct and direct you to make out the check to me and mail it as follows:

In Care Of
ISR Physical Therapy of Houma
478 Corporate Drive
Houma, LA 70360
(985) 872-5911 Fax (985) 872-6155

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of the Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize this provider to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated this ________ day of __________________, 20______.

____   ___________________________________
Signature of Policyholder or Claimant   Witness

____
Signature of Guarantor (if under 18, guarantor signature required)

ISR PHYSICAL THERAPY

OUR FINANCIAL POLICY

Thank you for choosing **ISR Physical Therapy** as your health care provider. We are dedicated to providing the best possible care and service to you and regard your understanding of your financial responsibilities as an essential element of your care and treatment. All patients must complete our information and insurance forms prior to being seen by the therapist.

PATIENT'S RESPONSIBILITY IS DUE AT TIME OF SERVICE:
WE ACCEPT cash, check or credit card payments

Commercial Insurance Carriers: We bill most insurance carriers for you if proper paperwork is provided to us. Changes must be brought to the attention of the clinic as soon as possible to ensure accurate billing. Any outstanding balances, co-insurance and deductibles are due prior to checking in for your appointments. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. Therefore, if your insurance company has not paid your account in full within 45 days, the balance will automatically be your responsibility regardless of any insurance company's arbitrary determination of usual and customary rates. ***Keep in touch:*** **Do not assume your insurance carrier is "working on it". Contact them if you have not received notice of payment to the clinic within 30 to 45 days of your services.**

Medicare: Our office is a Medicare participating provider and we will bill Medicare for you. We will bill your secondary insurances that automatically crossover through the CSM (Medicare System). If, your secondary insurance does not crossover it is the patient's responsibility for filing these claims. Any outstanding balances and deductibles are due prior to your appointments. Any co-insurance and non-covered services will be due as service is rendered.

Workers' Compensation: If your visit is work-related we will need the case number and carrier name prior to your visit in order to bill the worker's compensation insurance company. You are to notify ISR if and when your workers' compensation claim has settled.

Auto Accident: If your visit is related to an automobile accident, in addition to your private insurance information, your or the responsible party's claim number is required prior to your visit. Please inform us if there is any attorney involvement.

Attorney Case: If for any reason your law suit has an unfavorable settlement the full account balance is the patient's responsibility.

Interest: ISR will charge interest in the amount of 1.5% per month as provided by state law if the unpaid balance is not paid within 75 days of the treatment date.

Additional Fees: In addition, I agree that if payment is not made within 90 days from date of service and should this office find it necessary to place my account with a collection agency or attorney, I am to pay any and all court costs and attorney or collection fees at the rate of 38% or greater, on any balance due and owing.

Missed Appointments: We kindly ask that you let us know 24 hours in advance if you are unable to keep your appointment. No-shows and late cancelations will be charged at the rate of a normal office visit. We do not double book patients; and in consideration of other patients, we regret that late arrivals will not receive an extension of scheduled service time and will be responsible for full service/office fees. Some appointments may need to be cancelled due to late arrival.

NSF Checks: ISR will charge a fee of $25.00 for all NSF checks, which is to be paid by cash or money order. You may be placed on a "Cash Only" basis following any returned check.

Minor Patients: For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy:

X ______________________________ Date: ____________________
Patient Signature / Guarantor Signature (if under 18)

X ______________________________ Date: ____________________
Signature of Co-Responsible Party

ISR PHYSICAL THERAPY
AUTHORIZATION TO RELEASE OR OBTAIN HEALTH INFORMATION

Patient Name: ______________________________

Date of Birth: ______________________________

Social Security Number: ______________________________

Please read the following carefully:

(a) I understand that as part of my health care treatment, ISR Physical Therapy (the "Practice") develops and maintains records containing my health information, which include my health history, symptoms, test results, diagnosis, treatment, and claims and payment history.

(b) I hereby authorize a representative of ISR PHYSICAL THERAPY to be permitted to review, obtain and release copies of all hospital, medical, vocational, and other related records and to discuss pertinent information with professionals involved in my rehabilitation / physical therapy program.

(c) Furthermore, I hereby give permission to ISR to share the information received with any institution that through an insurance program or otherwise is paying all or part of the cost of my rehabilitation/ physical therapy program. This authorization permits the release of written reports and discussion of the client's condition.

ISR is authorized to obtain or release the following specific medical information *(initial all three below)* by the following methods:

________ Mail ________ Fax ________ e-mail

My authorization extends only to those data elements/documents initialed below:

☐ Entire Record ☐ Statements of charges or payments ☐ Progress Notes ☐ Discharge Summary
☐ Photographs, videotapes, digital or other images ☐ History and Physical Examination ☐ Consultation Report
☐ All office notes pertaining to my treatment ☐ Records of visits (all visits)
☐ Copies of records & reports to the below listed (i.e. employer, attorney, vocational rehab agency, insurances)

** ____
(name of healthcare provider, employer, attorney or other)

This authorization is given freely with the understanding that:

(a) Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
(b) A photocopy or fax of this authorization is as valid as this original.
(c) I may revoke this authorization at any time, except where information has already been released. This authorization is valid for a one year period from the date it is signed, or sooner if noted below. The revocation must be in writing. A revocation form is available from the receptionist.
(d) ISR Physical Therapy, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
(e) Treatment, payment, eligibility for benefits may not be conditioned upon obtaining this authorization.
(f) Information used or disclosed pursuant to this authorization may be subjected to re-disclosure by the recipient and is no longer protected by our organization.

Reason for release of Information: ☐ At request of individual ☐ Fit-For-Duty (FFD) ☐ Physical Therapy ☐ FCE ☐ Pre-Employment Screen	Date or event on which this authorization will expire:
If not the patient, name of person signing form:	Relationship to patient:

All items on this form have been completed and my questions about this form have been answered. It is to my understanding that a copy of this form is available to me upon request.

______________________________ ______________________________
Signature of patient or representative authorized by law Date

ISR Physical Therapy

Consent and Acknowledgment for Use and Disclosure of PROTECTED HEALTH INFORMATION

Patient Name: ________________________________

Date of Birth: ________________________________

Social Security Number: ________________________________
(for I.D. purposes)

Please read the following statements carefully:

a. I understand that as part of my health care treatment, ISR Physical Therapy and its subsidiaries (the "Practice") develops and maintains records containing my health information, which include information about my health history, symptoms, test results, diagnoses, treatment, and claims and payment history.

b. I understand that my health information will be used and disclosed by the Practice for Treatment, Payment and Health Care Operations and serves as:

- a basis for planning my care and treatment;
- a means of communicating among health professionals who may contribute to my care;
- a source of information to bill for health care services rendered;
- a means by which an insurance company or other third party payor can verify that services were billed were actually provided; and
- a resource for the practice's "health care operations", such as assessing quality of care and reviewing the competence of health care professionals.

c. I have been provided with the Practice's Notice of Protected Health Information Practices (the "Notice"), which provides a more complete description of the Practice's use and disclosure of my health information. I understand that I have the right to review the Notice prior to signing this consent form. I understand that the Practice can change the terms of the Notice and that the Practice reserves the right to make the new notice provisions effective for my health information that it already maintains and uses, as well as for any health information that it may receive in the future. Should such terms change, the Practice will mail a revised Notice to me at the mailing address contained in my medical record.

d. I understand that if I refuse to sign this consent form allowing for the use and disclosure of my health information to carry out treatment, payment or health care operations, the Practice may refuse treatment.

e. I understand that I have the right to request restrictions as to how my health information may be used and /or disclosed by the Practice to carry out treatment, payment or health care operations, but that the Practice is not required to agree to the restrictions requested. If, however, the Practice agrees to the requested restriction, it is binding on the Practice.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (*please specify: (1) what information you want to limit; (2) whether you want to limit the use, disclosure or both; and (3) to whom you want the limits to apply. Leave blank if no restrictions):*

____

____

f. I understand that I may revoke this Consent by notifying the Practice of my intent in writing. However, such revocation will not have any effect on uses or disclosures of my health information prior to the receipt of the revocation.

g. This consent is given freely with the understanding that:

- Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law;
- a photocopy or fax of this consent is as valid as this original;
- I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must agree to any restrictions in writing that I request on the use and disclosure of my Protected Health Information and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED THIS CONSENT AND AGREE TO THE PRACTICES USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

______________________________________ ____________________

Signature of Patient or Patient's Representative Date

____

Printed Name of Patient's Representative *(if applicable)*

____

Representative's Relationship to Patient *(if applicable)*

OFFICE USE ONLY

The requested restrictions on the use and/or disclosure of the patient's health information set forth in Paragraph (e) of this form are:

_______ Accepted _______ Denied _______ Not Applicable _______ No restrictions Noted

_________ Other *(please explain)*: ______________________________________

____

______________________________________ ____________________

Signature of Authorized Practice Representative Date