PATIENT INFORMATION

PLEASE PRINT DATE: _____

GENERAL INFORMATION

Name: _____

Address: _____
Street **City** **State** **Zip Code**

Name of Guarantor/Responsible Party (if applicable): _____

Address (if different from above):_____
Street **City** **State** **Zip Code**

Email Address: _____

Best Contact Phone:_____Work/Cell:_____

Social Security Number:_____ Referring Physician: _____

Gender: Male_____ Female_____ Date of Birth:_____

Marital Status: □Single □Married □Widowed □Divorced □Separated

Employer:_____ Occupation:_____

Emergency Contact: _____ Contact Phone Number:_____

SOCIAL HISTORY

Do you use or smoke tobacco products, now or in the past? YES____ NO____
How much and how often? _____

Do you drink alcohol? YES____ NO____
How much for day, week, or month? _____

YOUR MEDICAL HISTORY

_____Heart Attack
_____ Stroke
_____High Blood Pressure
_____Low Blood Pressure
_____ Diabetes
_____Epilepsy/Seizures
_____High Cholesterol
_____Headaches
_____Osteoperosis
_____Cardiac Issues:_____
_____Psychological Disorder:_____
_____ Cancer: _____
_____Other:_____

_____ Asthma
_____Anemia
_____Rheumatoid Arthritis
_____Thyroid
_____Pacemaker
_____Spinal Stimulator
_____Fibromyalgia
_____Peripheral Vascular

_____Lung Disease
_____ Kidney Disease
_____Liver Disease
_____Shortness of Breath
_____Gout
_____Fainting
_____Dizziness
_____TB

MEDICAL HISTORY

Is your injury the result of a car accident? _____ No _____Yes
If Applicable please provide the following: Date of injury/ Name of Insurance Company/ Claim Number/ and/or Attorney's Name and phone number_____
_____

Please list any allergies/ drug allergies:_____
_____

Please list all medications you are currently taking:_____
_____

Have you had any imaging studies done related to your current issue (xray, CT scan, MRI)?_____

Have you ever had surgery? _____No _____Yes If yes, please explain (include dates):
_____
_____

Have you ever had surgery recommended but not performed? _____No _____Yes
If yes, please explain_____
_____

Have you ever had a back injury? _____ No _____Yes
If yes, please explain_____

What is your goal for your physical therapy?_____

_____
Patient Signature Date

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Georgialina Physical Therapy Associates to furnish medical care and treatment to _____ considered necessary and proper in diagnosing and treating my physical condition. This may include the use of electrical current modalities, and I understand that there is potential for adverse reactions including, but not limited to: discomfort, allergic reaction, and skin redness and irritation. I understand it is my responsibility to inform my physical therapist of any allergies, previous reactions or medical conditions that may interfere with my care.

I, the undersigned give written consent for Georgialina Physical Therapy Associates to discuss my medical condition, to the extent necessary for third party reimbursement.

I, the undersigned, give written consent for Georgialina Physical Therapy Associates to discuss my treatment with my referring physician.

This consent is given freely and voluntarily. Any information shall not be released by the recipient without my written consent, except as mandated by State and Federal Law. In the event information is released by a third party to unauthorized persons, the undersigned hereby releases Georgialina Physical Therapy Associates from any and all liability for such unauthorized release of information. I understand except to the extent that action has been taken which was based on my consent and that I may withdraw this consent at any time.

PAYMENT POLICY AND ASSIGNMENT OF BENEFITS

Please provide all of your health insurance information so that we may file your claims properly. Please list your insurance carriers:

1. _____ 2. _____ 3._____

Primary Insurance **Secondary Insurance** **Tertiary Insurance**

We have customarily waited up to 30 days for payment from insurance companies. If your insurance company has not reimbursed us for services rendered within 30 days from the date filed, we ask that you make arrangements to pay your balance with this office.

If your services may be covered by Workman's Compensation or an Attorney is handling your injury case it is imperative that you notify our receptionist. Please indicate the name, address and phone number of your representing Case Worker / Attorney if the above statement applies:

_____ _____ _____

Case Worker/Attorney Name Address Phone Number

I understand that I am responsible for any balance due for professional services in excess of the benefits provided by my policy. I understand that if my insurance plan does not make payment within 30 days I will begin making monthly payments on the balance due.

I hereby agree that in the event of default in payment for any amount due and if this account is placed in the hands of a collection agency or attorney, I will pay an additional charge equal to the cost of collection agency fee, attorney's fee and court cost incurred and permitted by laws covering these transactions.

_____ Date: _____

Guarantor/Patient/Responsible Party

_____ Date: _____

Clinic Representative

We have partnered with The Family Y to promote health and wellness in our community. All Georgialina Physical Therapy patients receive discounted rates and exclusive benefits at participating Family Y locations. Please indicate if you would like more information about their programs. Yes_____ No_____

Revised 06/05/14

+Effective Date: April 14, 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.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU: The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures, we will elaborate on the meaning and provide more specific examples, if you request. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Payment. We may use and disclose medical information about you so that the treatment and services you receive at the clinic may be billed to and payment may be collected from you, an insurance company or a third party. For example: we may disclose your record to an insurance company, so that we can get paid for treating you.

For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you at the clinic or hospital. For example, we may disclose medical information about you to people outside the clinic who may be involved in your medical care, such as family members, clergy or other persons that are part of your care.

For Health Care Operations. We may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run the clinic and ensure that all of our patients receive quality care. We may also disclose information to doctors, nurses, technicians, medical students and other practice personnel for review and learning purposes. For example, we may review your record to assist our quality, improvement efforts.

Who Will Follow This Notice. This notice describes our clinic's policies and procedures and that of any health care professional authorized to enter information into your medical chart, any member of a volunteer group which we allow to help you, as well as all employees, staff and other clinic personnel.

POLICY REGARDING THE PROTECTION OF PERSONAL INFORMATION. We create a record of the care and services you receive at the clinic. We need this record in order to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the clinic, whether made by clinic personnel or by your personal doctor. The law requires us to: make sure all that medical information that identifies you is kept private; give you this notice of our legal duties and privacy practices with respect to medical information about you; and to follow the terms of the notice that is currently in effect. Other ways we may use or disclose your protected healthcare information include: appointment reminders; as required by law; for health-related benefits and services; to individuals involved in your care or payment of your care; research; to avert a serious threat to health or safety; and for treatment alternatives. Other uses and disclosures of your personal information could include disclosure to, or for: coroners, medical examiners and funeral directors; health oversight activities; inmates; law enforcement; lawsuits and disputes; military and veterans; national security and intelligence activities; organ and tissue donation; protective services for the President and others; public health risks; and worker's compensation.

NOTICE OF INDIVIDUAL RIGHTS

You have the following rights regarding medical information we maintain about you:

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you. To request this list or account of disclosures, you must submit your request in writing to the Privacy Officer.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by, or for, the clinic. To request an amendment, your request must be made in writing and submitted to the Privacy Officer and you must provide a reason that supports your request. We may deny your request for amendment.

Right to Inspect and Copy. You have the right to inspect and obtain a copy of medical information that may be used to make decisions about your care. We may deny your request to inspect and copy in certain very limited circumstances. A charge will be made for copies of these records.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or a certain location. You must make your request in writing and you must specify how or where you wish to be contacted. **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer.

CHANGES TO THIS NOTICE. We reserve the right to change this notice. We will post a copy of the current notice in the clinic's waiting room.

COMPLAINTS. If you believe your privacy rights have been violated, you may file a complaint with the practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the clinic, contact the Administrator at 803-441-0025. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION. Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written authorization. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you have any questions about this notice or would like to receive a more detailed explanation, please contact our Privacy Officer. **I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.**

_____ _____

Patient or Patient's Personal Representative **Date**

PATIENT FINANCIAL RESPONSIBILITY

Georgialina Physical Therapy requires a credit or debit card to be placed on file as a convenient method of payment for the portion of services for which you are personally responsible. This may include deductibles, co-pays, co-insurance, and cancellation fees. Patient statements are sent monthly and payment is due within 30 days of the statement date, unless a payment plan has been established with our billing office. Accounts that are overdue more than 30 days without an approved payment plan will have their credit card charged.

Please contact the billing department at 803-349-4118 for payment arrangements.

I, _____ understand this payment policy and understand that my credit card on file will be charged as indicated above.

Signature:_____Date:_____

Clinic Rep Signature:_____Date:_____

Appointment Attendance Policy Agreement:

Georgialina Physical Therapy is committed to providing all of our patients with exceptional care. When a patient fails to attend their appointment or cancels without giving adequate advanced notice, they prevent another patient from being treated.

Initial ☐ To avoid being charged a $25 fee for cancelling an appointment, please call us by 2:00 p.m. on the day prior to your scheduled appointment.

Initial ☐ To avoid being charged a $25 fee for cancelling a Monday appointment, please call our office by 2:00 p.m. on Friday.

Initial ☐ Failure to attend an appointment without notifying us of a cancellation will result in a $40 charge.

Initial ☐ These fees are the responsibility of the patient. Insurance Companies, Workers Comp Companies and Attorneys will NOT pay these fees.

Patient Signature:_____Date: _____

Clinic Rep Signature:_____Date:_____

THANK YOU FOR BEING COMPLIANT TO OUR NO SHOW AND CANCELLATION POLICY