

Patient Information

Last Name		First Name		MI	Date of Birth
Social Security Number		Gender <input type="radio"/> Male <input type="radio"/> Female		Marital Status <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Other	
Home Address		City		State	ZIP
Home Phone	Cell Phone	Email Address			
Employment Status <input type="radio"/> Full Time <input type="radio"/> Part Time <input type="radio"/> Student <input type="radio"/> N/A		Employer/School Name		Title/Position	
Work Address		City		State	ZIP
Work Phone		Have you been treated at any TherapySouth Clinic before? <input type="radio"/> No <input type="radio"/> Yes If yes, where?			
How did you hear about TherapySouth? <input type="radio"/> Physician <input type="radio"/> Friend/Family <input type="radio"/> Radio <input type="radio"/> Website <input type="radio"/> Print ad <input type="radio"/> Other _____					

Emergency Contact/Legal Guardian Information

Last Name		First Name		MI	Relationship to patient
Home Address		City		State	ZIP
Home Phone	Cell Phone	Email Address			

Primary Insurance Company Information

Primary Insurance Name		Secondary Insurance Name			
Policyholder Name (if other than patient)		Gender <input type="radio"/> Male <input type="radio"/> Female		Date of Birth (of policyholder)	
Social Security Number (of policyholder)		Phone Number (of policyholder)		Policyholder's relationship to patient	

Injury-Related Information

Attorney Name			Attorney Phone Number		
Attorney Address		City		State	ZIP
Auto Liability Company Name		Contact Name		Phone Number	
Auto Liability Company Address		City		State	ZIP
Auto Liability Claim Number					



Assignment of Benefits / Authorization of Release of Medical Information / Consent to Treatment

As the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility. I hereby assign all medical benefits to which I am entitled to TherapySouth in the event they file insurance on my behalf. I understand that I am Financially Responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment. I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection agency service fees, Attorneys fee, and all court costs and additional legal fees associated with the recovery of this debt. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of TherapySouth as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment except acts of negligence.

Patient Name (please print)

Authorized Signature

Today's Date

Patient Information

Patient Name			Today's Date			Date of Birth		
Gender <input type="radio"/> Male <input type="radio"/> Female	Age	Smoker <input type="radio"/> Yes <input type="radio"/> No	Pregnant <input type="radio"/> Yes <input type="radio"/> No	Height	Weight	Occupation		
Primary Care Physician			May we send your doctor your physical therapy evaluation? <input type="radio"/> Yes <input type="radio"/> No					

Past Medical History

Have you had an MRI or other imaging? <input type="radio"/> Yes <input type="radio"/> No If yes, please describe results:	
Have you had surgery(ies)? <input type="radio"/> Yes <input type="radio"/> No If yes, please list surgeries and approximate dates:	
Please check each condition you have been told you have/had:	
<input type="radio"/> Cancer	<input type="radio"/> Diabetes
<input type="radio"/> High Blood Pressure	<input type="radio"/> Heart Disease
<input type="radio"/> Osteoporosis/penia	<input type="radio"/> Osteoarthritis
<input type="radio"/> Allergies/Asthma	<input type="radio"/> Lung Disease
<input type="radio"/> Kidney Disease	<input type="radio"/> Stroke
<input type="radio"/> Angina/Chest Pain	<input type="radio"/> Ulcers
<input type="radio"/> Rheumatoid Arthritis	<input type="radio"/> Pelvic Pain
<input type="radio"/> Liver Disease	<input type="radio"/> Fibromyalgia
<input type="radio"/> Incontinence	
Have you had a recent illness? <input type="radio"/> Yes <input type="radio"/> No If yes, please explain:	
Do you take blood thinners? <input type="radio"/> Yes <input type="radio"/> No	Are you allergic to latex? <input type="radio"/> Yes <input type="radio"/> No
Do you have any other conditions? <input type="radio"/> Yes <input type="radio"/> No If yes, please explain:	
Have you had 2 or more falls in the last 12 months? <input type="radio"/> Yes <input type="radio"/> No	
Have you had any fall with injury in the last 12 months? <input type="radio"/> Yes <input type="radio"/> No	

Current Symptoms

What is your current activity level? <input type="radio"/> Sedentary <input type="radio"/> Active <input type="radio"/> Regular Exercise Routine			
Please check each condition you are currently experiencing:			
<input type="radio"/> Unexplained weight loss	<input type="radio"/> Shortness of breath	<input type="radio"/> Headaches	<input type="radio"/> Depression
<input type="radio"/> Changes in appetite	<input type="radio"/> Dizziness	<input type="radio"/> Numbness or tingling	<input type="radio"/> Changes in bowel/bladder
<input type="radio"/> Difficulty swallowing	<input type="radio"/> Poor balance (falls)	<input type="radio"/> Fever/chills/sweats	<input type="radio"/> Increased pain at night
<input type="radio"/> Nausea/vomiting			

Current Symptoms (continued)

Where are you currently having symptoms?	
How did it start? <input type="radio"/> Gradually <input type="radio"/> Suddenly <input type="radio"/> Injury	
What date (approximately) did your present pain start?	If injury, what was the injury date?
Where did injury occur? <input type="radio"/> Home <input type="radio"/> Work <input type="radio"/> Automobile <input type="radio"/> Sports	
Are your symptoms currently: <input type="radio"/> Getting better <input type="radio"/> About the same	
What is your CURRENT pain level, on a scale of 1-10?	
What has been your WORST pain level, on a scale of 1-10?	
Have you ever had this problem before? <input type="radio"/> Yes <input type="radio"/> No	
If yes, how was the problem treated?	
How long did it take for you to feel better?	
How well do you sleep at night? <input type="radio"/> Well <input type="radio"/> With moderate difficulty <input type="radio"/> Only with medication <input type="radio"/> Unable to sleep due to pain	
What is your personal goal for therapy?	



Patient Information Consent Form

I have read and fully understand the TherapySouth Notice of Patient Information Practices. I understand that TherapySouth 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 of 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 company in writing. I also understand that TherapySouth 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 TherapySouth Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the company in writing at any time.

Admission to our clinic is non-discriminatory for services rendered, regardless of race, color, national origin disability or age. All clients who come to our clinic for services are protected against discrimination assured by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

Thank you for allowing us the opportunity to serve you. If you have any questions about the above information of any uncertainty regarding your insurance coverage, please do not hesitate to ask for our assistance.

Designated Individuals Authorization

I hereby authorize one or all of the designated parties listed below to request and receive the release of any Protected Health Information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

_____	_____
Name	Relationship

_____	_____
Name	Relationship

_____	_____
Patient Name	Primary Care Physician

_____	_____
Patient Signature	Today's Date



Welcome to TherapySouth

Insurance Information

As a courtesy to you, we will bill your insurance company. Please provide us with your insurance card and any additional information we may need. We recommend that you call your insurance company to verify your physical therapy coverage if there is any discrepancy between what our office has been informed of and what you thought your benefit coverage was. It is your responsibility to know your policy benefits and limitations. Our billing office is available to answer questions you may have regarding our billing procedures.

Payment Options

We accept personal checks, cash, all major credit cards, and CareCredit. Insurance co-payments are due on each visit. Any portion of your treatments that are not covered by your insurance becomes your responsibility, and is due within 30 days. Interest may be charged at a rate of 1.5% per month (18% annually) for unpaid balances over thirty days old.

Return Check Fee

A \$35.00 fee will be charged to the patient for each incident that a check is returned to us for insufficient funds.

Collection of Accounts

A \$35.00 fee will be charged to the patient for any account turned over to collections for non-payment. Payment on account is due in full within 30 days from date of service.

Workers Compensation Claims

We will bill your open, approved workers' compensation claim. Please be advised that in the event your claim is denied, you are financially responsible for all charges.

Scheduling

We are happy to reschedule your appointments when a conflict occurs; however, we request a 24-hour notice if at all possible. If you fail to attend your appointments and do not give us 24 hour prior notification, you may be charged a fee of \$50.00 for the time slot allotted for you.

Non-Discrimination

Admission to our clinic is non-discriminatory for services rendered, regardless of race, color, national origin, disability, or age. All clients who come to our clinic for services are protected against discrimination assured by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

Thank you for allowing us the opportunity to serve you. If you have any questions about the above information or any uncertainty regarding your insurance coverage, please do not hesitate to ask for our assistance.

Patient Name (please print)

Patient/Legal Guardian Signature

Date



Notice of Patient Information Practices

This notice describes how medical information about you may be used or disclosed and how you can obtain access to information. Please review carefully.

TherapySouth Legal Duty

TherapySouth 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 disclosed herein.

Uses and Disclosures of Health Information

TherapySouth 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, TherapySouth 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.

TherapySouth may also use or disclose your personal health information without prior authorizations for public health purposes, for auditing purposes, and for emergencies. We may provide de-identified information for research studies. We also provide information when required by law.

In any other situation, TherapySouth 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.

TherapySouth may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of our clinic. 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 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. TherapySouth will consider all such requests on a case-by-case basis, but the company is not legally required to accept them.

Concerns And Complaints

If you are concerned that TherapySouth may have violated your privacy rights or if you disagree with any decisions made of regarding access or disclosure of your personal health information, please contact our HIPAA Compliance Office 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 TherapySouth health information practices, or if you have a complaint, please contact the following office:

HIPAA Compliance Office
TherapySouth
2823 Greystone Comm Blvd.
Birmingham, AL 35242
phone (205) 745-3650 | fax (205) 745-3649