LUBBOCK SPORTS REHAB

PATIENT NAME (LEGAL NAME):_____ SS#_____
PATIENT ADDRESS:_____CITY:_____STATE_____
ZIP:_____ HM PH # _____ WRK PH # _____ CELL # _____
EMAIL: _____
EMPLOYER'S NAME:_____ EMPLOYER'S ADDRESS:_____
SEX: ☐M / ☐F D.O.B.:___/___/___ STUDENT: ☐FT / ☐PT MARITAL STATUS:☐M☐S☐W
REFERRING DR._____ DATE OF SURGERY___/___/____
WERE THERE ANY INJURIES / ACCIDENTS? ☐Y ☐N ☐HOME☐WORK☐OTHER:_____
DATE OCCURED:___/___/___ DESCIRBE ACCIDENT / INJURY:_____
_____
HAVE YOU EVER HAD PHYSICAL THERAPY ☐YES ☐NO DATE: _____ WHERE:_____
HAVE YOU HAD PHYSICAL THERAPY AT THIS FACILITY ☐YES ☐NO WHEN: _____

IF WORKERS COMP: ADJUSTER NAME: _____ **PHONE # ( )**_____

RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

NAME:_____ SSN#_____ D.O.B___/___/___
ADDRESS:_____CITY:_____ STATE:____ ZIP_____
HM# _____ WRK PH# _____ CELL # _____
EMPLOYER:_____

INSURANCE PRIMARY

INSURANCE COMPANY NAME:_____ PHONE # _____
ID #_____ GROUP #_____ EMPLOYER:_____ WK#_____
INSURED NAME:_____ ADDRESS:_____
CITY:_____ STATE:_____ ZIP:_____ D.O.B.:___/___/___

INSURANCE SECONDARY

INSURANCE COMPANY NAME:_____ PHONE # _____
ID #_____ GROUP #_____ EMPLOYER:_____ WK# _____
INSURED NAME:_____ ADDRESS:_____
CITY:_____ STATE:_____ ZIP:_____ D.O.B.:_____

AUTHORIZATION AND CONSENT FOR MEDICAL TREATMENT/RELEASE OF INFORMATION

I authorize Lubbock Sports Rehab the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to Lubbock Sports Rehab for service provided. Lubbock Sports Rehab will file all claims to my health insurance. Should my health insurance fail to make payment, it will be my responsibility to pay the total balance due for services rendered.

I authorize Lubbock Sports Rehab and its staff to administer physical therapy treatment as considered therapeutically necessary on the basis of findings during the course of treatment.

_____ _____
Patient Signature *(Parent/Guardian if Patient under 18)* **Date/Time**

Revised 04/02/2015

LUBBOCK
Sports Rehab

FINANCIAL POLICY LETTER

Dear Patient,

We at Lubbock Sports Rehab (hereto referred as "Facility") are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive care in rehabilitation services today. In order to assist you with your health care investment, we provide the following payment options:

Payment Options

1. Cash – includes money orders and personal checks. Your driver's license is required on your checks for electronic processing.
2. Visa/MasterCard/Discover/American Express – we accept credit cards as payment for treatment to the extent your credit limit permits
3. Health Reimbursement Accounts and Health Savings Accounts – we accept HRA's and HSA's as forms of payment. It is patient responsibility to ensure that proper funds are in these accounts.

We would be happy to work with you to plan the most appropriate arrangement for your budget.

REGARDING HMOs, PPOs, and MANAGED CARE PROGRAMS

OFFICE POLICIES

We do participate in some of these programs. Please check with your plan. It is your responsibility to obtain referral forms, etc. required by your particular insurance company. You will be expected to pay a $250.00 deposit to cover any co-pays, deductibles or co-insurance at the time of your visit.

REGARDING MEDICARE

Facility is a non-Medicare facility. However, we are happy to provide you with a list of Medicare-providing facilities in the area upon request.

REGARDING PRIVATE PAY

We do provide the option of private pay. We will require a $250 deposit prior to being seen by the physical therapist. A recurring payment plan can be set up for any remaining treatment needed.

REGARDING OUTSTANDING UNPAID BALANCES AND COLLECTIONS

It is the Facility's policy to maintain proper and timely financial practices. It is also our goal to ensure our patients maintain good financial standing with the Facility. However, the Facility retains the right, in circumstances regarding outstanding and unpaid patient balances, to utilize Collectech Diversified, Inc. (CDI) for recoupment of these unpaid balances. The Facility and CDI have entered into an agreement that allows for the access to the Facility's appropriate records. The patient acknowledges that CDI will have access to Protected Health Information provided to the Facility, including but not limited to, cell phone numbers, home addresses, and other Protected Health Information.

IF YOU ARE A MINOR your parents or guardian need to accompany you to our office before treatment can be rendered.

IF YOU ARE A COLLEGE STUDENT we do not bill parents for services rendered. You may need to make arrangements prior to being seen with you parents for payment to be made at the time of treatment.

FEES FOR TREAMENT ARE PAYABLE AT THE COMPLETION OF EACH APPOINTMENT. IT IS ALWAYS YOUR RESPONBILITY TO SEE THAT YOUR ACCOUNT IS CURRENT AND PAID, REGARDLESS OF INSURANCE OR ANY OTHER CIRCUMSTANCE (SUCH AS LITIGATION)

INSURANCE GUIDELINES

The services you are receiving may not be paid or covered by your insurance company. You must agree to pay for all fees not paid by your insurance company and accept full liability.

Listed below are some reasons you will be responsible for the full amount, less any co-pays or payments made. (These are only some of the reasons and not a complete list of details of rejections).

- Your insurance has paid its share of the claim
- You have not met your deductible limit
- Non-covered service
- Insurance cancelled
- Insurance has not received information requested from you
- No contract with insurance company
- Claim over 90 days old – no action from insurance company
- No referral from Primary Care Physician
- Failure to present current insurance coverages

If our clinicians or facility is <u>out of network</u> with your insurance plans you may be responsible for larger deductibles and co-insurance. Please check with your insurance company for a list of network providers.

INSURANCE BENEFIT NOTICE

1. Insurance coverage is not a guarantee of payment
2. Benefits given to us by your insurance company is only a *"quote of benefits"* and not a guarantee of benefits until claims are processed by your insurance company.
3. If your insurance coverage has limitations, you may be liable for charges that exceed the limitations of your coverage.
4. If you have a co-pay, you are able to pay that at the beginning or end of every visit.
5. It is the patient's responsibility to list and inform the Facility of ALL INSURANCE POLICIES in a timely fashion. Any coverage that is reported after the required time for claim filing or after the patient has been discharged may be rejected and the patient will be held liable for the remaining balance.

I have read and understood the policies of the Facility. I agree to these terms and will abide by the regulations set forth by Facility and its associates. I have seen and acknowledged the Patient Insurance Verification form provided by Facility.

_____ _____

Patient / Responsible Party (if Patient is a minor) Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE AND RECORDS RELEASE

I (patient's name) _____ acknowledge that I have received a copy and have reviewed Lubbock Sports Rehab Notice of Privacy Practices. This Notice describes how Lubbock Sports Rehab may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information and my rights regarding my protected health information.

Please indicate any persons authorized to discuss your protected health information (PHI) with our office or those who are authorized to receive copies of your medical records. Include the person's name and relationship to yourself. Include a start date and an end date to set restrictions of any individual(s).

NAME	RELATIONSHIP	START DATE	END DATE

I acknowledge receiving Lubbock Sports Rehab handouts for my own personal information

- ☐ Financial Policy Letter
- ☐ Insurance Guidelines
- ☐ Office Policies

_____ _____

Patient- Signature/ Parent-Guardian Signature Date

If Parent-Guardian's Signature appears above, please describe Parent-Guardian's relationship to the patient: _____

HIPAA Notice of Privacy Practices

Revised 2013

Effective as of April14/2003
Revised September23/2013

Lubbock Sports Medicine
4110 22nd Place Lubbock, Texas 79410
806-792-4329

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.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR RIGHTS

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

Mendy Wyatt	806-792-4329	mendy@lubbocksportsmed.com
HIPAA COMPLIANCE OFFICER	Phone	email

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.