LUBBOCK
Sports Rehab

PATIENT INFORMATION

PATIENT (LEGAL NAME):_____ DOB:____/____/____

ADDRESS:_____ PH #: C_____

_____ H_____

EMAIL:_____ W_____

EMPLOYER:_____ SSN #:_____

EMPLOYER ADDRESS:_____

SEX: M ☐ F ☐ MARITAL STATUS: M ☐ S ☐ W ☐ STUDENT STATUS: FT ☐ PT ☐

REFERRING DR.:_____ DATE OF SURGERY: ____/____/____

DESCRIBE INJURY: _____

_____DATE OF INURY:____/____/____

HAVE YOU HAD ANY OTHER PHYSICAL THERAPY FOR THIS INJURY: Y ☐ N ☐ # OF VISITS: _____

RESPONSIBLE PARTY (if other than patient)

LEGAL NAME: _____ DOB:____/____/____

ADDRESS:_____ PH #: C_____

_____ H_____

EMPLOYER:_____ W_____

EMAIL:_____

PRIMARY INSURANCE:_____ RELATIONSHIP TO INSURED:_____

ID#_____ GROUP #:_____

INSURED (LEGAL NAME):_____ DOB:____/____/____

ADDRESS:_____ PH #: C_____

_____ H_____

EMPLOYER:_____ W_____

SECONDARY INSURANCE:_____ RELATIONSHIP TO INSURED:_____

ID#_____ GROUP #:_____

PATIENT (LEGAL NAME):_____ DOB:_____/_____/_____

ADDRESS:_____ PH #: C_____

_____ H_____

EMPLOYER:_____ W_____

TERTIARY INSURANCE:_____ RELATIONSHIP TO INSURED:_____

ID#_____ GROUP #:_____

PATIENT (LEGAL NAME):_____ DOB:_____/_____/_____

ADDRESS:_____ PH #: C_____

_____ H_____

EMPLOYER:_____ W_____

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 for 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 5/6/2022

LUBBOCK
Sports Rehab

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE AND RECORDS RELEASE

I (patient/guardian name) _____ acknowledge that I have received a copy and have reviewed Lubbock Sports Rehab Noice of Privacy Policies. 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 individuals.

NAME	RELATIONSHIP	START DATE	END DATE

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

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

_____ _____

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

If Parent/Guardian, please describe relationship to the patient: _____

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 – 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. Financing your treatment will allow you to begin your treatment and maintain good financial standing with the Facility.

OFFICE POLICIES

REGARDING HMOs, PPOs, and MANAGED CARE PROGRAMS

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 your co-pay 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. For this option, we request $90 for the initial visit and $65 per visit thereafter. A patient can participate in this option if the patient has no active insurance coverage, or is out-of-network with our facility with no out-of-network benefits, or wishes to waive their insurance coverage altogether.

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 accompanying insurance companies) 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

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.