A. Fox Physical Therapy, P.C.

DATE OF INTAKE:____________ DATE SCHEDULED:_______________

Called after Initial Evaluation:_______________ Called after Discharge:________________

NAME____ ***E-MAIL:** ____

1) PHONE: ____ **2) PHONE:** ______________________________________

ADDRESS___________________________________ **CITY** ___________________________ **STATE** ______ **ZIP** ________

BIRTHDATE _____ /_____/______**SOCIAL SECURITY #**_____________________________ Male____ Female____

How were you injured?___________________________________ **When were you injured/symptoms start?**_____________

Body area/Diagnosis/Description of probelm:____

Are the following activities being affected? __ Sleeping __Walking __Standing __Sitting __Going to the restroom

HOW DID YOU HEAR ABOUT OUR CLINIC? (Please give name)

Physician:_________________Friend/Family:____________________Advertisement:_______________Other:______________

REFERRING PHYSICIAN NAME, PHONE,CITY____

FREQUENCY/ DURATION_____________________ PRIMARY CARE PHYSICIAN: ______________________________

EMPLOYER_________________________________ STATUS: FT/PT Employed Light Duty Disabled Retired Student

MARITAL STATUS____________________SPOUSE NAME & PHONE: ____

EMERGENCY CONTACT (Name, Relation, Phone Number):____

PAYMENT INFORMATION

HEALTH

INSURANCE CARRIER____

PH:________________________ ID #________________________ GROUP #_______________________

PERSON RESPONSIBLE FOR THIS ACCOUNT____

SECONDARY INSURANCE CARRIER____

PH:________________________ ID #________________________ GROUP #_______________________

I have **INSURANCE** and would like to . . .

__ Have you deal directly with them. My coinsurance/Copay is $____________ My deductible is $_________________

__ Get a discount by paying the entire bill at the time of service. I'll get reimbursement on my own. (Ask for details)

WORKMAN'S COMP

ADJUSTER(if_applicable)__________________________________PH:_____________________________

CLAIM/POLICY #_____________________________________EMPLOYER INSURING CLAIM_________________________

AUTO

___I have **Med Pay**? Insurance Name _________________________________ Phone:_____________ Cl#
________________________Amount$ ___

___ **Lien:** I have an Attorney and would like to pay upon the time of settlement.

Attorney's Name and office address:____________________ ____________________________

Phone: _____________ Fax: __________________

___I prefer to pay ahead of time for my services, take advantage of the cash pay discount, and be reimbursed upon settlement of my case.

PRIVATE PAY

___ I am paying by cash, check or credit card at the time of service to take advantage of the cash pay discount.

___ I am taking advantage of the Payment Plan option and have read and agree to the terms of such. _______________

Credit Card (Safe and Secure. I understand I will be notified of any and all charges prior to processing) *Required for Payment Plan

__Visa __MC __AmEx __Discover CC# ____ Expiration Date _____/______

Name on Card: ____________________________ Billing Address ___________________________ City_________________

State ___ Zip_________

PLEASE READ THE BACK SIDE FOR POLICIES **AND SIGN**

PATIENT RELEASE OF MEDICAL RECORDS AND ASSIGNMENT OF BENEFITS

PLEASE READ AND INITIAL THE RELEASE AND CONFIDENTIALITY AGREEMENT. IF YOU HAVE QUESTIONS REGARDING THE PATIENT INFORMATION POLICIES, PLEASE BRING THEM TO OUR ATTENTION.

I hereby authorize A. Fox Physical Therapy, P.C. to release to my insurance company or its representatives, and other health care professionals working on my medical case, any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical care.
I also authorize and request my insurance company to pay directly to the above named physical therapy clinic the amount due for services rendered.
I understand that it is my responsibility to call my insurance company to verify coverage for physical therapy through my policy, and agree to pay any co-pays, deductibles, and any other portions that my insurance company will not pay. If I cancel my appointment with less than 24 hour notice I will be charged, and agree to pay, for the visit.
In the event payment is not received within 30 days of statement date, my account will be subject to an interest charge per month. If no payment is made, my account will be placed with a collection agency for the amount due as well as collection fees.
I have read and fully understand A. Fox Physical Therapy, P.C.'s Notice of Information Practices. I understand that A. Fox Physical Therapy, P.C. 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 or payment. I understand that I have the right to designate individuals to whom my information can be released. 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 practice. I also understand that A. Fox Physical Therapy, P.C. 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 A. Fox Physical Therapy, P.C.'s Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.
I also authorize A. Fox Physical Therapy, P.C. to use my protected health information for A. Fox Physical Therapy, P.C.'s targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

NOTICE OF PATIENT INFORMATION PRACTICES: A. Fox Physical Therapy, P.C.'s LEGAL DUTY. A. Fox Physical Therapy, P.C. 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 described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

A. Fox Physical Therapy, P.C. 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, A. Fox Physical Therapy, P.C., or information about treatment alternatives or other health related benefits that could be of interest to you.
A. Fox Physical Therapy, P.C. may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.
In any other situation, A. Fox Physical Therapy, P.C.'s 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.
A. Fox Physical Therapy, P.C. may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. 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 related 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. A. Fox Physical Therapy, P.C. will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that A. Fox Physical Therapy, P.C. may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager 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 A. Fox Physical Therapy, P.C. health information practices or if you have a complaint, please contact the following person: Anne-Marie Fox

BENEFITS

As a courtesy to our patients we will verify benefits, however the benefits quoted are not a guarantee of payment. It is the patient's responsibility to verify and get a thorough understanding of their medical benefits specific to A. Fox Physical Therapy, P.C. The patient is responsible for all charges not reimbursed by their insurance carrier including but not limited to coinsurance, deductibles, and any charges associated with collection activity; billing fees for co-pays not paid on the date of service and any portion of the account that exceeds 30 days past due should you fail to reimburse A. Fox Physical Therapy, P.C. for amounts due for services rendered. In the even of default, you agree to pay all collection agency fees in the amount equal to 40% of the outstanding balance, and reasonable attorney fees.

Patient /Parent or Guardian (Please Print and Sign) Date

I HAVE READ AND UNDERSTAND ALL OF THE POLICIES PERTAINING TO PATIENT INFORMATION PRACTICES AND I AUTHORIZE A. FOX PHYSICAL THERAPY, P.C.
TO RENDER THE APPROPRIATE PHYSICAL THERAPY TREATMENT ACCORDING TO REASONABLE AND CUSTOMARY PHYSICAL THERAPY PRACTICE.