AUTHORIZATION TO TREAT AND CONSENT TO OBTAIN INFORMATION

I give my consent for Accelerated Physical Therapy and Occupational Health, Inc. to verify my insurance coverage and to obtain information from any source to determine whether I qualify for benefits. I authorize any holder of medical or other information about me to release any information needed for this or a related claim. I certify that I understand the type of service to be provided to me by Accelerated Physical Therapy and Occupational Health, Inc. I certify that I understand the supervisory relationship between the individual consultants, therapists, etc. service provision and Accelerated Physical Therapy and Occupational Health, Inc.

_____ _____

PATIENT SIGNATURE DATE

If the patient is unable or not competent to sign, the authorized party must sign the patient's name and indicate that they are signing another's name by then signing their own signature. One witness signature is also required in this case.

_____ _____ _____

PATIENT NAME AUTHORIZED PERSON DATE

_____ _____

WITNESS SIGNATURE DATE

PERMISSION TO BILL

I authorize Accelerated Physical Therapy and Occupational Health, Inc. to bill all insurance programs for services provided to the above member by Accelerated Physical Therapy and Occupational Health, Inc. I assign these insurance benefits to Accelerated Physical Therapy and Occupational Health, Inc. I also designate Accelerated Physical Therapy and Occupational Health, Inc. as my agent to file for reconsideration or review to the highest available appeals if insurance should deny payment.

_____ _____

SIGNATURE OF MEMBER, LEGAL GUARDIAN OR RESPONSIBLE PARTY DATE

PAYMENT OBLIGATION

I understand and agree that I am responsible for any portion of payment not covered by my insurance policies and balances not paid within thirty (30) days of filing of claim by Accelerated Physical Therapy and Occupational Health, Inc. and will make regular payments of co-pay and deductible amounts as requested by Accelerated Physical Therapy and Occupational Health, Inc. I understand that any balance on my account which remains unpaid thirty (30) days after my account is submitted for insurance payment or I am billed will be assessed a month interest charge of 1.5%. I understand that I am responsible for any necessary charges to collect this debt, including but not limited to collection fees, attorney fees, or court costs for failure to pay for services. I authorize Accelerated Physical Therapy and Occupational Health, Inc. to receive information on claims status.

Estimated Deductible Amount_____ **Int**

Estimated Co-insurance of co-pay Amount_____ **Int**

_____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE

Accelerated Physical Therapy and Occupational Health, Inc.

833 Highway 90, Suite 2
Bay St. Louis, MS 39520

4405 East Aloha Drive, Suite D
Diamondhead, MS 39525

Notice of Privacy Practices

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.

Uses and Disclosures We will use your protected health information (PHI) for the purposes of treatment, payment and health care operations.

Treatment includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians, and other physical therapists. For example, we may feel that a stroke patient we are treating would benefit from an evaluation by a speech-language pathologist to address a swallowing difficulty. The health information we share with the speech-language pathologist would be considered a treatment related disclosure.

Payment includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was necessary.

Health care operations include the utilization of your records to monitor the quality of care being given at our facility or for business planning activities.

Other Special Uses

Our practice may use your PHI to send you an appointment reminder, to inform you of our other health-related products and services, or to request a contribution to our charitable activities.

Uses and Disclosure Required by Law

The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions.

Complaints

If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy

We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment form us.

Source: American Physical Therapy Association

ACCELERATED
physical therapy & occupational health, inc.

PRACTICE REQUIREMENTS

The Practice

(a) Is required by federal law to maintain the privacy of your Private Health Information (PHI) and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI
(b) Under the Privacy Rule, may be required by State Law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.
(c) Is required to abide by the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of you PHI that it maintains.
(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all that it maintains.
(e) Will distribute any revised Privacy Notice to you prior to implementation.
(f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This notice is in effect as of April 15, 2003.

PATIENT ACKNOWLEDGEMENT

By signing my name below I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to it's terms.

_____

Patient Signature Patient Printed Name

_____

Date

Mailing Address:
P.O. Box 3497 • Bay St. Louis, MS 39521
www.acceleratedpt-ms.com

833 Highway 90, Suite 2
Bay St. Louis, MS 39520
228.463.9030
fax 228.463.0103

4405 E. Aloha Drive, Suite D
Diamondhead, MS 39525
228.255.3888
fax 228.255.3836

DIAGNOSIS: _____ CODE: _____

PATIENT INFORMATION

DATE: _____ SOCIAL SECURITY #: _____

NAME: _____ EMPLOYER: _____

ADDRESS: _____ ADDRESS: _____

CITY: _____ STATE: _____ CITY: _____ STATE: _____

ZIP:_____ ZIP: _____

PHONE: _____ CELL: _____ PHONE: _____

E-MAIL ADDRESS: _____

BIRTHDATE: _____ FAMILY PHYSICIAN: _____

HEIGHT: _____ WEIGHT: _____ REFERRING PHYSICIAN: _____

SEX:_____ EMPLOYMENT STATUS: _____ ADDRESS: _____

SINGLE MARRIED WIDOWED DIVORCED CITY/STATE: _____

DATE OF ONSET: _____ PHONE: _____ ZIP: _____

(FOR OFFICE USE ONLY: Doctors NPI # _____)

PERSON RESPONSIBLE FOR PAYMENT

NAME: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

RELATIONSHIP: _____

CONTACT IN CASE OF EMERGENCY

NAME: _____ PHONE: _____

RELATIONSHIP: _____

(CIRCLE ONE)

IS CONDITION/INJURY EMPLOYMENT RELATED? YES NO ____Initial

IS CONDITION/INJURY ACCIDENT RELATED? YES NO ____Initial

IS CONDITION/INJURY THE RESULT OF A LEGAL LIABILITY? YES NO ____Initial

ATTORNEY NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

ACCELERATED
physical therapy & occupational health, inc.

SUPPLY AGREEMENT

Some patient's may need to be issued supplies, (neck brace, back brace, carpal tunnel splints, theraband for exercising, traction units, etc.), as part of their plan of care. These supplies may, or may not, be covered by the insurance carrier. We will attempt to help you determine if a particular policy covers supplies but it is ultimately the responsibility of the patient to know their own insurance plan.

Please read and acknowledge below:

I understand that any supplies issued to me during my treatment may not be covered by my insurance carrier and I will be responsible for payment of any amount not covered by my insurance for such supplies.

_____

Patient Signature Date

Mailing Address:
P.O. Box 3497 • Bay St. Louis, MS 39521
www.acceleratedpt-ms.com

833 Highway 90, Suite 2
Bay St. Louis, MS 39520
228.463.9030
fax 228.463.0103

4405 E. Aloha Drive, Suite D
Diamondhead, MS 39525
228.255.3888
fax 228.255.3836

ACCELERATED PHYSICAL THERAPY AND OCCUPATIONAL HEALTH, INC.

MEDICAL HISTORY

Patient Name:_____ Date:_____

Have you had or currently have any of the following:

____AIDS	____Emphysema	____HIV
____Anemia	____Epilepsy	____Kidney Disease
____Anorexia	____Gall bladder trouble	____Rheumatic Fever
____Arthritis	____Glaucoma	____Seizures
____Asthma	____Heart Attack	____Stroke
____Back Injury	____Heart condition	____Thyroid condition
____Bronchitis	____Heart Failure	____Tuberculosis
____Coronary Artery Disease	____Hepatitis	____Ulcers
____Diabetes	____High blood pressure	

List any other conditions or surgeries not listed above:_____

_____

List of allergies:_____

Smoke? Yes____ No____ Quit within last 5 years____ If yes, how many packs per day?_____

Alcohol consumption? Yes____ No____ If yes, how many drinks per week? _____

Which, if any, of your family has had any of the following diseases, conditions or syndromes?

Cancer:_____

Diabetes:_____

Heart
Disease:_____

High Blood Pressure:_____

Kidney Disease:_____

Tuberculosis:_____

Please circle any symptoms present:

Abdominal Pain	Chest Pain	Edema	Irregular Heart Beat	Shortness of Breath
Blood in Stool	Constipation	Fatigue	Nausea	Temporary Blindness
Blood in Urine	Cough	Fever	Night Sweats	Urinary Tract Infection
Bloody sputum	Decreased Hearing	Free bleeding	Painful urination	Vomiting
Chills	Diarrhea	Hands/feet swelling		Weakness
Chronic sputum	Dizziness	Hoarseness	Ringing in Ears	Recent weight loss/gain