PATIENT INTAKE FORM

PATIENT'S CONTACT AND EMPLOYMENT INFORMATION

Last Name: _____ First Name: _____ (MI): _____

Home Address: _____ City, State, Zip: _____

DOB: ____/____/_____ Gender: ☐ M ☐ F Marital Status: _____ SS#: _____

(H) Phone: _____ (W) Phone: _____ (C) Phone: _____

Permission to send appointment reminders: ☐ Home Voicemail ☐ Cell Voicemail ☐ Cell Text

Email Address: _____

Occupation: _____ Employer_____

Emergency Contact: _____ Phone #_____

REFERRAL AND INJURY INFORMATION

Referring Physician: _____

Body Part: _____ Onset Date: _____

How did you hear about Accelacare? _____

Signature: _____ **Date:** _____

********** **FOR OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE** **********

INSURANCE INFORMATION

Ins. Company: _____ Type of Plan: _____ Secondary Ins: Yes No

Policy #: _____ Group #: _____ Phone #: _____

Secondary Ins. Company: _____ Type of Plan: _____

Policy #: _____ Group #: _____ Phone #: _____

POLICY HOLDER'S INFORMATION

Policy Holder**:** _____ Relationship to Patient: _____

DOB: _____ Employer Name: _____

Home Address: _____

1800 Palace Drive, Suite C, Garden City, KS, 67846
620-271-0700 I www.accelacarept.com

FINANCIAL POLICY

We are pleased to have you as our patient, and we are committed to providing you with our best professional care. Your clear understanding of our Financial Policy is important to our relationship. We reserve the right to refuse service for any reason, including but not limited to non-compliance in coming to therapy, acting disrespectfully to our staff and other patients or for unpaid balances. We reserve the right to require payment in full of unpaid balances before scheduling any subsequent appointments or services.

PPO/HMO/Commercial Plans: We will file your claims to your insurance provider. **Copays, coinsurances and deductibles are due at the time of service**. Should your insurance provider need additional information from you for the processing of our claim, it is your responsibility to assist by expediently providing the necessary information to your insurance provider. It is in your best interest to assist your insurance provider in obtaining all requisite information for their payment of your treatment, as you are ultimately responsible for the payment of any amounts accrued for treatment. **Please be aware of your coverage benefits for physical therapy. It is ultimately your responsibility to be informed and to comply with the financial obligations your insurance imposes. A benefits quote is not a guarantee of payment; it may be subject to other plan limitations or exclusions.**

❑ **Initials: _____**

State Insurance Plans: We will file your claims to your insurance provider. State plans have a limited number of authorized visits within an authorized date range. Should you exceed your plan's terms, you may have to get reauthorization for continued care. Should your insurance provider need additional information from you for the processing of our claim, it is your responsibility to assist by expediently providing the necessary information to your insurance provider. It is in your best interest to assist your insurance provider in obtaining all requisite information for their payment of your treatment, as you are ultimately responsible for the payment of any amounts accrued for treatment. **Please be aware of your coverage benefits for physical therapy. It is ultimately your responsibility to be informed and to comply with the financial obligations your insurance imposes. A benefits quote is not a guarantee of payment; it may be subject to other plan limitations or exclusions.**

❑ **Initials: _____**

Self-Pay/Private Pay Patients: If you do not have insurance, or physical therapy benefits are not covered by your insurance plan, we **require payment in full at the time of service**, unless prior payment arrangements have been discussed. We accept cash, checks and all major credit cards.

❑ **Initials: _____**

Personal Injury Protection: As a courtesy, we will file your claim to your insurance company. However, you are ultimately responsible to see that the account is paid in full. Your insurance policy is an agreement between you and your insurance company. Should the insurance need additional information from you for the processing of our claim, we require that you assist in the prompt payment of the claim by expediently providing the necessary information to your insurance company; otherwise the balance will be transferred to your responsibility. **It is your responsibility to research and notify our practice of your PIP limits as such information is not made available to us**. If our claims are denied due to maximum benefits being exhausted, you will be responsible for the balance due. All statements sent to you will be 30 days from the date of statement for payment in full unless prior payment arrangements have been discussed.
PIP: _____ OPEN CLAIM: _____

❑ **Initials: _____**

Medicare: We are participating Medicare Providers, and do accept assignment from Medicare. Please advise our office if you have secondary/tertiary insurance, so that we may file the claim to your secondary/tertiary carrier for the remaining **20% coinsurance or deductible not payable by Medicare**. You will receive a statement showing any remaining balance owed by you once all insurance providers have processed and paid/denied your claims. **CAP: $_____ _____ Visits**

❑ **Initials: _____**

Workers Comp: Workers Compensation patients must provide the following before being seen by a physical therapist: Claim Number, date of injury and name of adjustor. If your **workers comp claim is denied**, you will be **responsible for payment**. If your claim is in **litigation, you are responsible for payment**. Upon denial, please provide us with your health insurance information so that we can bill your health carrier, or you may pay for services in full. **AUTH VISITS _____**

❑ **Initials: _____**

Financial Notice: We accept **CASH**, **CHECK** and/or **VISA/MASTERCARD/DISCOVER/AMERICAN EXPRESS**.
The terms of the payment plan include no more than a **20%** "prompt pay reduction" wherein, if you timely make each monthly payment, you will receive no more than a **20%** reduction to the initial balance due. Payments will be due each month on or before the date you choose. We will charge you as little as $75 per month until we know the amount of your patient responsibility. Once we have determined your patient responsibility, we will notify you and set up a payment amount and payment term for the remaining balance. We will provide you a written notice of the agreed-upon payment terms. Should you fail to make timely payments, in the full amount prescribed, the payment agreement shall become void and the entire balance shall be due immediately. In such an event, Accelacare shall notify you via written correspondence to the address provided herein. Upon notification of your default, you shall pay the entire amount due immediately. Should you move or change addresses, it is your responsibility to notify Accelacare of such an address change.

Upon receipt of my patient responsibility, I agree to the following payment plan terms: **Monthly Payment_____ Term _____** I agree to pay the monthly payment specified herein for the terms specified. If I do so, I will be eligible for the no more than 20% "prompt pay reduction." I also acknowledge that upon completion of the payment plan, I may still have a remaining balance for which I am responsible. I agree to set a payment arrangement for the remaining balance.

❑ **Initials: _____**

Collections: If you need to make a payment arrangement due to financial hardship, our Business Office requires patients to call to make mutually satisfactory payment arrangements. If your insurance provider does not remit payment within 60 days, you shall be responsible for the payment of the entire account balance accrued. In executing this document, I understand and agree that I am personally responsible for payment regarding all services rendered to me, my dependents, or any others assigned by me to my account. Should I fail to pay any balance accrued by me; I shall be responsible for all costs and court costs incurred by Accelacare, including the payment of reasonable attorney's fees. **If the account is in default and turned over to collection, I acknowledge that I will be responsible for all reasonable costs associated with effectuating collection**. If during the admission or application process I have provided a cell phone number; I acknowledge that I may be contacted at that number for account servicing matters, including but not limited to collecting on my account should it become delinquent.

❑ **Initials: _____**

Cancellations/No Shows: All cancellations made without prior **24 hour** notice or No Shows will be assessed a fee of **$25.00**. Insurance does **NOT** cover late cancellation/no show fees; therefore, any fees due will be collected from you on your next scheduled visit.

❑ **Initials: _____**

Patient Name (PRINT): _____

Signature: _____ Date: _____

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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 this document carefully.

About Protected Health Information (PHI)
In this Notice, "we," "our" or "us" means this Accelacare Physical Therapy and Occupational Services and our workforce of employees, contractors and volunteers. "You" and "your" refers to each of our patients who are entitled to a copy of this Notice.

We are required by federal and state law to protect the privacy of your health information. For example, federal health information privacy regulations require us to protect information about you in the manner that we describe here in this Notice. Certain types of health information may specifically identity you. Because we must protect this health information, we call this Protected Health Information---or "PHI." In this Notice, we tell you about:

- How we use your PHI
- When we may disclose your PHI to others
- Your privacy rights and how to use them
- Our privacy duties
- Who to contact for more information or a complaint

Some of the ways we use (within the organization) or disclose (outside of the organization) your Protected Health Information
We will use your PHI to treat you. We will use your PHI and disclose it to get paid for your care and related services. We use or disclose your PHI for certain activities that we call "health care operations". We will also use or disclose your PHI as required or permitted by law. We will give you examples of each of these to help explain them but space does not permit a complete list of all uses or disclosures. This is one reason why you can contact us and ask us questions.

1. Treatment
   We use and disclose your PHI in the course of your treatment. For instance, once we have completed your evaluation or re-evaluation we send a copy or summary of our report to your referring physician. We also maintain records detailing the care and services you receive at our facility so that we can be accurate and consistent in carrying out that care in an optimal manner; that record also assists us in meeting certain legal requirements. These records maybe used and/or disclosed by members of our workforce to assure that proper and optimal care is rendered.

2. Payment Involving a Third Party Payer
   After we treat you we will, typically, bill a third party for services you received. We will collect the treatment information and enter the data into our computer and then process a claim either on paper or electronically. The claim form will detail your health problem, what treatments you received and it will include other information such as your social security number, your insurance policy number and other identifying pieces of information. The third party payer may also ask to see the records of your care to make certain that the services were medically necessary. When we use and disclose your information in this way is helps us to get paid for your care and treatment.

3. Payment Exclusive of a Third Party Payer (fully self-pay)
   If you choose to pay for your services, in full, without involving a third party (insurer, employer, etc.) you may request that we do not disclose any information regarding your services for payment purposes.

4. Health Care Operations

We also use and disclose your PHI in our health care operations. For example our therapists meet periodically to study clinical records to monitor the quality of care at our facility. Your records and PHI could be used in these quality assessments. Sometimes we participate in student internship programs and we use the PHI of actual patients to test them on their skills and knowledge. Other operational used may involve business planning and compliance monitoring or even the investigation and resolution of a complaint.

5. Special Uses

We also use or disclose your PHI for purposes that involve your relationship to us as a patient. We may use or disclose your PHI to:

- Update your workers compensation case worker or employer
- *Remind you of appointments*
- *Carry out follow ups on home programs that you have been taught*
- *Advise you of new or updated services or home supplies (you can choose to opt-out of receiving any notices of this kind)*
- *Release equipment and/or supplies to your designee*
- *Carry out follow ups on your home programs or discharge planning*
- *Advise you of new or updated services or home supplies via telecommunication or via a newsletter (you can choose to opt-out of receiving information of this nature from us)*
- *Carry out research that does not directly identify you*
- *Carry out marketing functions such as providing nominal promotional gifts (you can choose to opt-out of receiving any marketing information or items from us)*
- *Contact you regarding fundraising projects that we are engaged in (you can choose to opt-out of any fundraising project notification that we engage in)*

Note: If we receive direct or indirect financial remuneration from a third party for marketing a product or item or for any fundraising we are engaged in we will offer you the opportunity to 'opt out' from receiving any of these materials.

6. Uses & Disclosures Required or Permitted by Law

Many laws and regulation apply to us that affect your PHI, they may either require or permit us to use or disclose your PHI. Here is a list from the federal health information privacy regulations describing required or permitted uses and disclosures:

Permitted

- If you do not verbally object, we may share some of your PHI with a family member or a friend if he/she is involved in your care
- We may use your PHI in an emergency if you are not able to express yourself
- If we receive certain assurance that protect your privacy, we may use or disclose your PHI for research; Accelacare Physical Therapy and Occupational Services will always obtain an authorization from you even though it is 'permitted' without one.

Required

- When required by law; for example, when ordered by a court to turn over certain types of your PHI, we must do so
- For public health activities such as reporting a communicable disease or reporting an adverse reaction to the Food and Drug Administration
- To report neglect, abuse or domestic violence
- To the government regulators or its agents to determine whether we comply with applicable rules and regulations
- In judicial or administrative proceedings such as a response to a valid subpoena

- When properly requested by law enforcement officials or other legal requirements such as reporting gunshot wounds
- To advert a health hazard or to respond to a threat to public safety such as an imminent crime against another person
- Deemed necessary by appropriate military command authorities if you are in the Armed Forces
- In connection with certain types of organ donor programs
- Stricter Requirement That We Follow

Some state regulations are more stringent than federal privacy regulations so we comply with those laws.

7. Your Authorization May Be Required

In the situations noted above we have the right to use and disclose your PHI. In some situations, however, we must ask for, and you must agree to give, a written authorization that has specific instructions and limits on our use or disclosure of your PHI. If you change your mind, at a later date, you may revoke your authorization.

8. Your Privacy Rights and How to Exercise Them

You have specific rights under our federally required privacy program. Each of them is summarized below:

- Your Right to Request Limited Use or Disclosure
  You have the right to request that we do not use or disclose your PHI in a particular way. However, we are not required to abide by your request. If we do agree to your request we must abide by the agreement; we have the right to ask for that request to be in writing and we will exercise that right.
- Your Right to Confidential Communication
  You have the right to receive confidential communications from us at a location or phone number that you specify. We have the right to ask for that request to be in writing noting the other address or phone number and confirmation that it should not interfere with your method of payment; we will exercise the right to have your request in writing.
- Your Right to Inspect and Copy Your PHI
  You have the right to inspect and copy your PHI. If we maintain our records in paper, that will be the format utilized; however if we maintain our records electronically you have the right to review and/or have copies made in an electronic format. Should we decline we must provide you with a resource person to assist you in the review of our refusal decision. We must respond to your request within *thirty (30) days*, we may charge reasonable fees for copying and labor time related to copying and we may require an appointment for record inspection; we have the right to ask for your request in writing and will exercise that right.
- Your Right to Revoke Your Authorization
  If you have granted us an authorization to use or disclose your PHI you may revoke at any time it in writing. Please understand that we relied on the authority of your authorization prior to the revocation and used or disclosed your PHI within its scope.
- Your Right to Amend Your PHI
  You have a right to request an amendment of your record. We have the right to ask for the request in writing and we will exercise that right. We may deny that request if the record is accurate and/or if the record was not created by this facility. If we accept the amendment we must notify you and make effort to notify others who have the original record.
- Your Right to Know Who Else Sees your PHI
  You have the right to request an accounting of certain disclosure that we have made over the past six years. We do not have to account for all disclosures, including those made directly to you, those involving treatment, payment, health care operations, those to the family/friend involved with your care and those involving national security. You have the right to request the accounting annually. We have the right to ask for the request in writing and to charge for any accounting requests that occur more than once per year; we must advise you of any charge and you have the right to withdraw your request or to pay to proceed.

- You have a right to be informed of a breach your protected health information
  We are required to notify the patient by first class mail or by e-mail (if indicated a preference to receive information by e-mail), of any breaches of unsecured Protected Health Information as soon as possible, but in any event, no later than *sixty (60) days* following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:
  a) A description of the breach, including the date of the breach and the date of its discovery, if known
  b) A description of the type of unsecured protected health information involved in the breach
  c) Instructions regarding the measures the patient should take to protect him/her from potential harm resulting from the breach
  d) Correction action Accelacare Physical Therapy and Occupational Services* has/will take to investigate the breach, mitigate losses, and protect the patient from further breaches
  e) Accelacare Physical Therapy and Occupational Services* contact information, including a toll-free telephone number, e-mail address, Web site or postal address for additional questions.
- You Have a Right to Complain
  You have the right to complain if you feel your privacy rights have been violated. You may complain directly to us by contacting our HIPAA officer noted in Section 10, or to the:
  U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/
  We will not retaliate against you if you file a complaint about us. Your complaint should provide a reasonable amount of specific detail to enable us to investigate your concern.
- The Patient Has the Right to Receive a Copy of the Privacy Notice
  Accelacare Physical Therapy and Occupational Services* is obligated to provide the patient with a copy of its Notice of Privacy Practices and to post the Notice in a conspicuous place for patients to access as well as on our website. We have the right to change the Notice to comply with policy, rules or regulatory changes; we are obligated to give new notices to current and subsequent patients as changes are made. We are required to maintain each version of a Privacy Notice for a minimum of six (6) years.

9. Some of Our Privacy Obligations and How We Perform Them
   - We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach that may have compromised the privacy or security of your information.
   - We must follow the duties and privacy practices described in this notice and give you a copy of it.
   - We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

   If we change our Notice of Privacy Practices we will provide our revised Notice to you when you next seek treatment from us.

10. Contact Information
    If you have questions about this Notice, or if you have a complaint or concern, please contact:
    Name: Accelacare Physical Therapy and Occupational Services
    Address: 1800 Palace Drive. Suite C
    Garden City, KS 67846
    Phone: 620-271-0700

11. Effective Date: This revised notice takes effect on June 20, 2016.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Accelacare Physical Therapy. I also authorize Accelacare Physical Therapy or my insurance provider to release any information required to process my claims.

I understand that it is my responsibility to know my insurance benefits and whether or not the services I am about to receive are covered benefits. I understand and agree that I will be financially responsible for any cost-share or balance due that Accelacare Physical Therapy is unable to collect from my insurance carrier due to any limitations on my plan coverage. If the account is in default and turned over for collection, I acknowledge that I will be responsible for all reasonable costs associated with effecting collection.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it and I understand my rights as stated therein.

In addition, I authorize the release of information to the individuals/entities identified below by name and relationship:

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Patient Name (PRINT) **Date**

_____ _____

Patient/Parent/Guardian Signature **Date**

_____ _____

Facility Representative **Date**

_____ _____