Welcome to Midwest Physical Therapy Services!!

Full Name: _____ DOB: _____ Gender: Male Female

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Which phone number is your primary number to reach you? Home Cell Work

Do you give us permission to leave a message on your answering machine? Yes No

Email [optional]: _____ would you appreciate information via email about clinic events and weekly reminders regarding your therapy? Yes No

Would you appreciate email message reminders about your appointments? Yes No

Marital Status [circle one]: Single Married Divorced Widowed N/A

SSN: _____ Driver's License: _____

Emergency Contact Name: _____ Relationship: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

May we discuss your medical information with this person? Yes No

*Are there additional parties you would like to allow discussion of your medical information with? Yes No

Primary Physician: _____ Office: _____

Can we ask how you heard about us? _____

For minors, responsible party information:

Full Name: _____ DOB: _____ Gender: Male Female

Relationship to patient: _____

Address [skip if same as patient]: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Email: _____

Marital Status [circle one]: Single Married Divorced Widowed N/A

SSN: _____ Drivers License: _____

I verify that all of the above information is correct to the best of my knowledge

Signature: _____ Date: _____

Parent [if minor]: _____ Date: _____

WELCOME TO MIDWEST PHYSICAL THERAPY SERVICES
Financial Policy

We are committed to providing you with the best possible care. If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

If you have insurance, we will be happy to file your insurance claims, however, it is your responsibility to make sure the claims are being paid in a timely manner. While we are able to verify insurance coverage, most insurance carriers will not guarantee payment until they receive the claim and diagnosis. Your coverage may be subject to limitations and we encourage you to check with your insurance company regarding your particular plan.

MEDICARE GUIDELINES

If you have received home health or outpatient physical therapy through another clinic, ***please advise us****. A written referral signed and dated by your physician is required. There must be evidence in the clinical record maintained by the therapist that a physician has seen the patient at least every 90 days. Therefore, it is the patient's responsibility to make an appointment with his/her referring physician every 90 days from the date of the initial evaluation, if physician has not agreed to therapist's plan of care in order for Medicare to reimburse for the services rendered.*

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

Payment is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. This includes charges not covered by insurance, Co-Pays, Co-Insurance, and Deductible. To help meet your Deductible, we will collect $100 on your visit until your Deductible is met. You may receive a bill for additional Deductible due. Coinsurance will be billed. They are due at the time of receipt and will be mailed on the 1st and the 15th of every month. If you are unable to pay the full amount, a payment plan may be arranged for you. We accept cash, check, or credit card.

A fee of twenty-five (25) dollars will be charged if a client does not arrive for a scheduled appointment without at least 24 hours notification or cancellation. This charge will not be submitted to the client's insurance and will be the sole responsibility of the client. *Cancelling 2 or more visits makes you eligible for discharge.*
Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1.33% per month. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions, **PLEASE** do not hesitate to ask us. We are here to help you and appreciate that you have chosen our clinic for your care.

Thank you,

Midwest Physical Therapy Services

_____ _____

Signature *Date*

_____ _____

Parent (if minor) *Date*

This form instructs your Insurance Company to send payment for your treatment directly to Midwest Physical Therapy Services. We will send this form to your Insurance Company to do the following listed in the box below. If your Insurance Company does not follow what is in your contract as well as ours, we will send a complaint to the Nebraska Insurance Commissioner.

MIDWEST PHYSICAL THERAPY SERVICES
11640 Arbor Street, Ste 200
Omaha, NE 68144

For the professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

Patient authorizes the Physical Therapist and/or Midwest Physical Therapy Services to deposit checks received on Patient's account for treatment when made out to the Patient from the insurance company.

I authorize the Physical Therapist and/or Midwest Physical Therapy Services to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

_____ _____

Signature *Date*

_____ _____

Parent (if minor) *Date*

MIDWEST PHYSICAL THERAPY SERVICES 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.

Our practice is dedicated and required by applicable federal and state laws to maintain the privacy of your health information. These laws also require us to provide you with this Notice which informs you of your rights and our obligations concerning your health information. We are required to follow the privacy practices described below while this Notice is in effect. We reserve the right to change this Notice and the privacy practices described below at any time in accordance with applicable law. Prior to making significant changes to our privacy practices, we will alter this Notice to reflect the changes and make the revised Notice available to you on request. **You may request a copy of our Notice at any time.**

PERMITTED USES AND DISCLOUSURES OF HEALTH INFORMATION

- **TREATMENT, PAYMENT, HEALTHCARE OPERATIONS:** You should be aware that during the course of our relationship with you we will likely use and disclose health information to you for treatment, payment, and healthcare operations.
- **Authorizations:** You may specifically authorize us to use your health information for any purpose or to disclose your health information to anyone by submitting such an authorization in writing. Upon receiving an authorization from you we may use or disclose your health information in accordance with that authorization. You may revoke an authorization at any time by notifying us in writing.
- **DISCLOSURES TO FAMILY AND PERSONAL REPRESENTATIVES:** We must disclose you r health information to you as described in the Patient Rights sections of this Notice. Such disclosures will be made to any of you personal representatives appropriately authorized to have access and control of your health information. We may disclose your health information to a family member, friend, or other persons to the extent necessary to help with your healthcare or payment for your healthcare only if authorized to do so. In the event of your incapacity or in emergency circumstances we will disclose health information health that based on a determination using our professional judgment only disclosing health information that is directly relevant to the person's involvement in your healthcare.
- **MARKETING:** We will not use your health information for marketing communications without your written authorization.
- **PATIENT AND THIRD PARTY PROTECTON:** Only as permitted by law we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.
- **USES AND DISCLOSURESPROVIDED BY LAW:** We may use or disclose your health information when we are required to do so by law including for public health reasons (i.e. disease reporting). In some instances and in accordance with applicable law we may be required to disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes.
- **LAW ENFORCEMENT/NATIONAL SERCURITY:** Under certain circumstances we may disclose health information relating to members of the Armed Forces to military authorities. Under certain circumstances we may also disclose health information relating to inmates or patients to correctional institutions or law enforcement personnel having lawful custody of those individuals. We may disclose health information in response to judicial proceedings and law enforcement inquires as permitted by law.
- **APPOINTMENT REMINDERS:** We may use of disclose your health information to provide you with appointment reminders (i.e. voicemail messages, postcards, or letters).

PATIENT RIGHTS

- **ACCESS TO RECORDS:** Upon submission of a written request to us you have the right to review copies of your health information with limited exceptions. You may request that we provide copies in a format other than photocopies and we will use the format you request if it is readily available. We will charge you a reasonable cost-based fee relating to the production of such copies.
- **ACCOUTNING OF CERTAIN DISCLOSURES:** Upon written request you have the right to receive a list of instances in which we or our business associates disclosed your health information for a fee. Contact us using the information for purposes other than treatment, payment, healthcare operations and other activities authorized by you for the last 7 years.
- **RESTRICTIONS AND ALTERNATIVE COMMUNICATIONS:** You have the right to request that we place additional restrictions on the use or disclosure of your health information for treatment, payment, and healthcare operation purposes. Depending on the circumstances of your request we may or may not agree to those restrictions. If we do agree to your requested restrictions we must abide by those restrictions except in emergency treatment scenarios. You have the right to request we communicate with you about your health information by alternative means or alternative locations. Such requests must be made in writing and must provide satisfactory explanation how payments will be handled under the alternative means of location you request.

Thank you, Midwest Physical Therapy Services

Acknowledgement of receipt of Notice of Privacy Practices

I acknowledge that I have reviewed, understand, and agree to the Notice of Privacy Practices of Midwest Physical Therapy, which describes the Practice's policies and procedures regarding the use and disclosure of any of my protected health information created, received, or maintained by Midwest Physical Therapy Services.

_____ _____

Signature / Parent (if minor) *Date*

Permission to communicate

Patient Name: _____ Date of Birth: _____

I authorize **Midwest Physical Therapy Services** to share my protected health information with family members or others as designated by me below. This permission is NOT an authorization to release medical records, or a consent to treatment. This permission also authorizes **Midwest Physical Therapy Services** to communicate with the authorized persons by phone (including voice messages), in person, or by other means acceptable to **Midwest Physical Therapy Services.**

Name _____

Relationship to Patient_____

Phone number_____

- ○ **Information permissions**
- ○ **Appointments only**
- ○ **Medical only**
- ○ **Financial Only**
- ○ **All the above**

Name _____

Relationship to Patient_____

Phone number_____

- ○ **Information permissions**
- ○ **Appointments only**
- ○ **Medical only**
- ○ **Financial Only**
- ○ **All the above**

Name _____

Relationship to Patient_____

Phone number_____

- ○ **Information permissions**
- ○ **Appointments only**
- ○ **Medical only**
- ○ **Financial Only**
- ○ **All the above**

I understand that I am under no obligation to provide **Midwest Physical Therapy Services** with this Permission to Communicate, and that **Midwest Physical Therapy Services** will not condition treatment, payment, or enrollment/eligibility for benefits on my decision to provide or not provide this form. I understand that I may revoke this Permission if I so choose. I can revoke this Permission either by completing a new Permission to communicate form and indicating my revocation on the form, or by notifying **Midwest Physical Therapy Services** in writing of my revocation.

Signature of Patient: _____ **Date:** _____

PATIENT ELECTION TO SELF-PAY FOR SERVICES

I,_____ , the undersigned patient, Acknowledge that I understand and agree that: initial all that apply

1. Do not have any medical insurance coverage _____
2. provider with **Midwest Physical Therapy Services** is not participating with _____("Company") _____
3. I am not covered by one of the Company health insurance plans. _____
4. The health plan under which I am covered excludes in network benefits for some or all of the services provided by **Midwest Physical Therapy Services**. _____
5. Despite the above, for private reasons protected by the HIPPA HITECH OMNIBUS RULE, I do not wish **Midwest Physical Therapy Services** to submit a claim to _____Company for services provided to me by **Midwest Physical Therapy Services**. _____
6. Until such time as I may otherwise advise **Midwest Physical Therapy Services** in writing, I elect to pay for all services I receive from **Midwest Physical Therapy Services** at their Self Pay rates. _____
7. By election to self-pay for services, any payments I make to **Midwest Physical Therapy Services** may not be credited toward satisfying any deductible (depending on your insurance policy and our participation) I may be subject to under my health insurance plan with _____Company unless otherwise permitted under the terms of my health plan.
8. I have read this Election to Self-Pay for Services form and have had the opportunity to ask any questions I may have had about the form. Any questions I may have had about this form have been answered to my satisfaction. _____
9. I have freely chosen to self-pay for services after having asked **Midwest Physical Therapy Services** about payment options and having carefully considered those options. _____

In Network insurances: Blue Cross Blue Shield of Nebraska, Medicare Part B, Railroad Medicare, Wellcare of Nebraska, Nebraska Total Care, Healthy Blue, Tricare, Coventry Medicare Advantage, Medicare Supplements

Insurances that we may or may not be In network with according to each individual plan:
Humana, Cigna, Midland's Choice, Auto accident cases, Worker's comp

Insurance that we do not participate with: Out of state Medicaid, Aetna, United Healthcare

Date:_____ Patient:_____

_____ _____
Signature of patient or responsible party
if patient is a minor or is otherwise unable to sign for him/herself

_____
Printed Name of Patient or Responsible Party