CLINIC 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 leave phone voice messages? ☐Y ☐N Where to leave messages? H☐ W☐ C☐

Email Address____

Emergency Contact____________________________________Phone #_______________________________

Patient's Occupation__________________________________Patient's Employer______________________

Referral and Injury Information:

Referring Physician ____

Body Part Injured ____Date of Injury___________________

Accident Type and Details ____

How did you hear about Accelacare? ____

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

Insurance Information:

Ins. Company ______________________________Type of Plan _______________Secondary INS ☐Y ☐N

Policy # ______________________Group # ___________________ Phone # ________________________

Policy Holder's Information:

Policy Holder ____________________________________Relationship to Patient _____________________

DOB _________________Employer Name ____

Home Address ____

(H) Phone _____________________(W) Phone _____________________(C) Phone ___________________

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.

PPO/HMO/Commercial Plans: We will file your claims to your insurance. Copays, coinsurances and deductibles are due at the time of service. 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. 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.

Self-Pay/Private Pay Patients: If you don't have insurance or physical therapy benefits are not covered by your 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.

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 net 30 days for payment in full unless prior payment arrangements have been discussed.

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 balance due by you once all insurances have processed and paid/denied your claims.

Workers Compensation: Workers Compensation patients must provide the following before being seen by a physical therapist: Claim Number, date of injury and name of the 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.

Collections: We accept ***CASH***, ***CHECK*** and/or ***VISA/MASTERCARD/DISCOVER/AMERICAN EXPRESS***. 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 carrier does not remit payment within 60 days, you are responsible for the entire b ill and the balance will be due, in full, from you. I understand and agree that all services rendered me, my dependents, or others assigned by me to my account are directly charged to me. I further I am personally responsible for payment. Should the fees for the services not be paid in accordance with the provisions herein, reasonable attorney's fees, plus applicable finance charges and disbursements, allowances and costs provided by law shall be included in the computation of the amount due. Finance charges can be applied to all amounts that are at least 30 days past due at the rate of 1.5% per month (18% annual rate). **If the account is in default and turned over to collection, I acknowledge that I will be responsible for all reasonable costs associated with effecting 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.

Cancellation/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.

Patient Name: ____ Date: ________________________

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. This notice takes effect on the date the acknowledgement is signed and remains in effect until we replace it.

1. Our pledge regarding medical information:

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. Our legal duty:

Law requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practice, we will change this notice and make the new notice available upon request.

3. Use and disclosure of your medical information:

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

For treatment: We may use medical information about you to provide you with the medical treatment for services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

For payment: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third party payer. The information on or accompanying the bill may include your medical information.

For health care operations: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

Additional uses and disclosures: In addition to using and disclosing your medical information for treatment, payment and health care operations, we may use and disclose medical information for the following purposes:

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facility directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional

judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.
Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.
Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.
Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.
Funeral Director, Coroner, and Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.
Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.
Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.
Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling a disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purpose of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.
Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.
Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.
Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.
Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.
Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

4. Your individual rights:

You Have a Right to:

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must

make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you a flat fee of $35 and postage if you want the copies mailed to you. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6. If you have received this notice electronically, and wish to have a paper copy, you have the right to obtain a paper copy by requesting in writing to the contact person listed at the end of this notice.

Questions and Complaints:

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. You may contact us to submit a complaint or submit requests involving any of your rights in Section 4 of this notice by writing to the following address:

Accelacare Physical Therapy LLC
c/o Medical Records
1800 Palace Drive, Suite C
Garden City, KS 67846

We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

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 insurance company 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 accounts 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:_____________________

Print Patient Name: Date:

____ ___________________________

Patient/Parent/Guardian Signature: Date:

____ ___________________________

Facility Representative: Date:

____ ________________________