



**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: \_\_\_\_\_

### 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 want to ensure that we provide the appropriate services for your needs and that you are able to receive care with transparency surrounding the cost involved.

**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 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 may have a limited number of authorized visits within an authorized date range. Should you exceed your plan’s terms, reauthorization is required 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 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 assignments 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. Per calendar year the Medicare Cap and Deductible are as follows. **CAP: \$2110.00 Deductible: \$203. Approx: 25 Visits/year**

**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 be responsible to pay for services in full.

**Initials:** \_\_\_\_\_

We accept **CASH, CHECK** and/or **VISA/MASTERCARD/DISCOVER/AMERICAN EXPRESS.** You may also apply payments on your account at any time through our secure website payment portal at [www.accelacarept.com](http://www.accelacarept.com).

**Initials:** \_\_\_\_\_

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.

**Initials:** \_\_\_\_\_

**Financial Notice:**

The following consent is a mutually agreed upon payment plan to account for unforeseen circumstances in which you may not be able to pay your balance in full within 90 days of your last date of service. This does not preclude you from making payments towards your balance during your ongoing plan of care and you are able to initiate a consistent payment plan before the 90 days if you so choose.

You may decline the option of a payment plan upfront. At the end of 90 days from your last date of service, if a balance remains, one of our front office team members will call to discuss monthly payment plan options. In this case you agree to set up a payment plan for an amount that matches your financial situation at that time and is mutually agreed upon.

A payment plan requires a card to be kept on file. The agreed upon amount will be applied to your card on the same date of your choice each month. We prefer to set a plan in which the balance is paid in full within 1 year of the initiation of the payment plan.



This agreement will remain in effect until **Accelacare Physical Therapy** has received written notification of changes at such time and in such manner as to afford **Accelacare Physical Therapy** a reasonable opportunity to open a discussion between both parties to alter the terms of this agreement.

**Initials:** \_\_\_\_\_

**Collections:**

Our billing department will make every attempt to work with you to resolve account balances. You will be notified of outstanding balances by receiving statements by mail. In the event that you no longer maintain financial responsibility towards your account and Accelacare has been unable to reach you to establish terms that are beneficial to both parties for repayment, we will notify you of your defaulted account by collection calls, and/or certified letters in hopes of initiating a payment plan. In the event we are unable to set up a payment plan we will turn your account over to a collection agency.

I acknowledge that I will be responsible for all reasonable costs associated with effectuating collection. If during the registration 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:** \_\_\_\_\_



## 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 identify 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 reevaluation 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 may be 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 it 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 uses 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 regulations 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 avert 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 an 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 email), 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/](http://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 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

1800 Palace Drive, Suite C, Garden City, KS, 67846

620-271-0700 | [www.accelacarept.com](http://www.accelacarept.com)





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 \_\_\_\_\_