South Shore Physical Therapy & Sports Medicine

CONSENT FOR CARE & TREATMENT

I, the undersigned, do hereby agree and give my consent for ***South Shore Physical Therapy & Sports Medicine*** to furnish medical care and treatment to ____considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian/Responsible Party ____Date____________________

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to ***South Shore Physical Therapy & Sports Medicine***. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Patient/Guardian/Responsible Party____Date____________________

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal ***usual and customary fee schedule***, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to ***South Shore Physical Therapy & Sports Medicine***.

The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you. **If WC, please initial to acknowledge understanding__________**.

When you pay by check, you expressly authorize ***South Shore Physical Therapy & Sports Medicine***, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limit (plus any applicable sales tax). Please note: the above language authorizes an electronic debit to your account for the state-allowed recovery fee. In accordance with the rules of the National Automated Clearing House Association, you may call (888) 235-4635 to revoke the authorization for the electronic transaction. This does not, however, mean that ***South Shore Physical Therapy & Sports Medicine***, cannot collect a returned check fee by other methods.

I understand and agree that if I fail to make any of the payments or which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

Information Privacy: ***South Shore Physical Therapy & Sports Medicine*** will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. The undersigned acknowledges receipt of this information.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

____ ________________________

Patient/Guardian/Responsible Party **Date**

____

____

Center Representative/Witness **Date**

HAWAII STATE TAX POLICY

It is the policy of South Shore Physical Therapy & Sports Medicine to apply Hawaii State Tax to services rendered when appropriate. In the event your insurance does not cover Hawaii State Tax, you will be responsible for the outstanding amount.

CANCELLATION POLICY

Our goal at South Shore Physical Therapy & Sports Medicine is to provide you with the highest quality physical and occupational therapy services available. To achieve your rehabilitation goals, it is essential that you attempt to keep all of your scheduled appointments. We have provided you with the reserved time slot and ask that if you must cancel your appointment, please **provide 24 hours notice.**

If you cancel your appointment less than 24 hours before your scheduled time, you will be charged $**50.00**. Your insurance does not cover this fee and you will be held personally responsible for payment. (Please see below if you are a Workers' Compensation patient).

____ ________________

Patient's signature Date

WORKERS' COMPENSATION

If you are covered by Workers' Compensation, you will not be assessed a $25.00 charge. However, we are required to notify your physician, case manager and insurance company of non-compliance with your schedule.

SouthShore Physical Therapy & Sportsmedicine

Medical Profile Questionnaire

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, the staff will assist you. Thank You!

Name:	Age:
Occupation:	Hours worked per week:
Leisure Activities/Hobbies:	

Are you currently seeing any of the following?:

Medical Doctor	Yes	No
Osteopath	Yes	No
Dentist	Yes	No
Psychiatrist/Psychologist	Yes	No
Physical Therapist	Yes	No
Chiropractor	Yes	No

If you have been seen by any of the above during the past 3 months, please describe for what reason (illness, medical condition, physical examination, etc.):

____

____

____

____

Have you EVER been diagnosed as having any of the following conditions?

Cancer, if yes describe what kind:	Yes	No
Heart Problems	Yes	No
High Blood Pressure	Yes	No
Asthma	Yes	No
Emphysema	Yes	No
Chemical dependency	Yes	No
Thyroid Problems	Yes	No
Diabetes	Yes	No
Multiple Sclerosis	Yes	No
Rheumatoid Arthritis	Yes	No
Other arthritic conditions	Yes	No
Depression	Yes	No
Hepatitis	Yes	No
Tuberculosis	Yes	No
Stroke	Yes	No
Kidney Disease/Bladder Problems	Yes	No
Anemia	Yes	No
Epilepsy	Yes	No
Other:		

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

Date Surgery/Hospitalization Reason:

_________ ____
_________ ____
_________ ____
_________ ____

Please describe any injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

Date Injury:

_________ ____
_________ ____
_________ ____
_________ ____

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

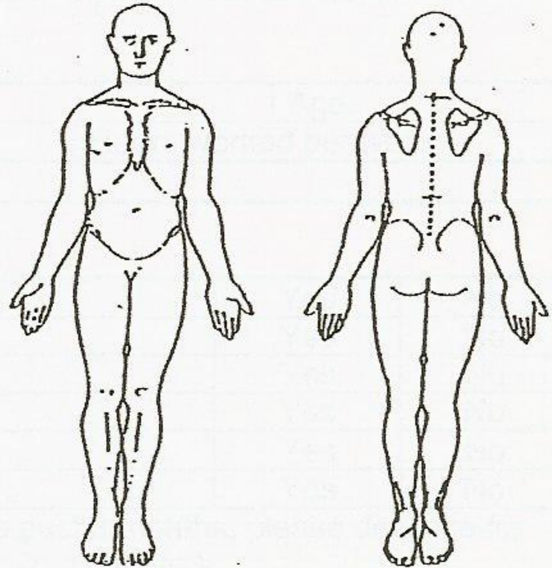
Aspirin	Yes	No
Tylenol/Acetaminophen	Yes	No
Advil/Motrin/Ibuprofen	Yes	No
Laxatives	Yes	No
Decongestants	Yes	No
Antihistamines	Yes	No
Antacids	Yes	No
Vitamins/Mineral Supplements	Yes	No
Other:		

Please list any PRESCRIPTION medication you are **currently** taking (Including pills, injections, and/or skin patches?):

____
____
____
____

Shade in on the BODY CHART, or describe in WORDS, where you feel your pain or symptoms.

____
____
____
____



On a scale of zero to ten, with zero (0) "NO PAIN", ten (10) as the "WORST PAIN you can imagine", rate:
The best it has been _____ The worst It has been ______.
Your pain today ________.

What makes your pain or symptoms **BETTER**?

____
____
____

What makes your pain or symptoms **WORSE**?

____
____
____

What do you hope to gain from Physical Therapy? Goals for Physical Therapy?

____
____

For **WOMEN** Check if YES

☐ I had a recent pelvic exam (PAP)
☐ I am or may be pregnant
☐ I have had a recent mammogram or breast exam

For **MEN** Check if YES

☐ I have had a recent prostate exam

_______________________________ ______
Patient/Guardian Signature Date

South Shore Physical Therapy & Sports Medicine

NOTIFICATION of PATIENT RESPONSIBILITY for CO-PAYMENTS/CO-PERCENTAGES and DEDUCTIBLES

Your insurance company requires South Shore Physical Therapy & Sports Medicine to collect your co-payments/co-percentages and any unmet deductible amounts from you at the time of service. If we do not collect these amounts we could be in violation of our contract with your insurance company and risk being denied reimbursement for your treatment.

South Shore Physical Therapy & Sports Medicine has verified Outpatient Physical Therapy / Occupational Therapy / Speech Therapy benefits based on the information furnished to us by you. Your Insurance Company has the disclaimer that this is a verification of benefits and not a guarantee of payment. Based on the information your insurance company provided to us, the amount that you are responsible for is:

Co-Payment _________________/Visit

Co-Percentage _________________/Visit ****ESTIMATED amount $___________________/Visit**

Deductible Amount __________________ **Amount Not Met____________________**

(*Please note - If you have already paid your annual deductible to another provider but our claim is received first by your insurance company, the deductible will be applied to our claim and you will owe the balance to South Shore PT. You will then need to obtain a refund from the provider that originally collected your deductible.)**

Maximum Visits/Days ________________________________ **Per Person / Condition / Year / Lifetime**

Maximum Dollar Amount ____________________________ **Out of Pocket Maximum_____________**

Other Benefit Information____

NOTE: ESTIMATED coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility for their account balance. The estimation is based on a negotiated contract and any remaining balance due will be billed to you after additional information is received from your insurance company. Reimbursement of services are based on your specific insurance plan, any discrepancies are strictly between you and your insurance carrier.

You may receive statements from us during and after your treatment. This is to keep you informed of the amount billed to your insurance company and the payments received from you and your insurance company. Due to the timing of processing your payments, some statements may not reflect all payments paid by you to date. In these cases, subsequent statements will reflect those payments.

If you have any questions or concerns about your billing, please contact us at (808) 879-0077.

Please verify that you understand your financial responsibility by signing and dating this form and let us know if we can assist you in any other way.
Thank you.

____
Patient Name (Printed)

____
Patient Signature **Date**

____
South Shore Physical Therapy & Sports Medicine **Date**