SCARBOROUGH PHYSICAL THERAPY ASSOCIATES, P.A. Referral Date _____

PATIENT INFORMATION Therapist/Date _____ Chart # _____

Last Name | First Name | M.I. | Date of Birth | Social Security #

Mailing Address | City | State | Zip | Home Telephone

Email address | Status: S M O (Circle One)

Employer | Occupation | Work or Cell Telephone

Person to contact in Emergency | Relationship to Patient | Daytime Telephone

POLICYHOLDER/INSURED INFORMATION ___ Check here if the same

Name of Policyholder/Insured | Date of Birth | Social Security # | Relationship to Patient

Mailing Address | City | State | Zip | Home Telephone

Employer | Occupation | Work Telephone

PAYOR INFORMATION ___ Check here if the same

Party Responsible for Payment | Date of Birth | Social Security # | Relationship to Patient

Mailing Address | City | State | Zip | Home Telephone

Employer | Occupation | Work Telephone

MEDICAL INFORMATION

Diagnosis | Date of Onset/Injury

Cause of Injury | Related To: Work | Auto

Referring Physician | Telephone # | Primary Care Physician | Telephone #

Past Surgeries

MEDICAL PROBLEMS: *Please check all those, which apply*

Diabetes	_____	Skin	_____	Kidney	_____	Throat	_____
Arthritis	_____	Genital/Pelvis	_____	Bleeding Problems	_____	Mouth	_____
Heart/Vascular	_____	Vision	_____	High Blood Pressure	_____	Allergies	_____
Abdominal	_____	Hearing	_____	Urinary	_____	Asthma	_____
Breathing Problems	_____	Seizures	_____	Cancer	_____	Stomach Problems	_____
Hepatitis B	_____	Headaches	_____	Nose	_____	Pacemaker	_____

1. Are you allergic to Penicillin? Yes____ No ____ Have you ever had a reaction to Penicillin? Yes _____ No _____
2. Are you allergic to any other drug? Yes ____ No ____ *If so, please list:* _____
3. Are you currently taking any medication? *Please list:* _____
4. Do you have any food allergies? Yes ____ No ____ *If so, please list:* _____
5. Female Patients: Are you Pregnant? Yes ____ No ____ Is there a possibility you are Pregnant? Yes ____ No____

In the event of an emergency, which hospital would you prefer to go to? _____

SCARBOROUGH PHYSICAL THERAPY ASSOCIATES, P.A

51 U.S. Route One, Scarborough, ME 04074 **Telephone: (207) 883-1227 Fax: (207) 883-6199**

CONSENT TO USE AND DISCLOSE FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I consent to Scarborough Physical Therapy Associate's (SPTA) use and/or disclosure of my protected health information (PHI) in support of my diagnosis and treatment; payment for physical therapy services I receive from SPTA; and the healthcare operations of SPTA. Further, I hereby authorize SPTA to administer such physical therapy procedure necessary to the reasons for which I am consulting them. Other disclosures of my PHI, including without limitation those relating to mental health, HIV/AIDS status or substance abuse, if any, may require me to sign a separate authorization.

I hereby authorize insurance payments directly to SPTA for credit to my account. If my policy prohibits direct payment to the provider, then I hereby instruct that the check made payable to me be forwarded to SPTA.

I understand that I am financially responsible for any and all charges not covered by my insurance plan(s). I understand that any dispensed supplies not paid by my insurance company will be my responsibility. If my account is referred for collection, I will be responsible for all fees required to collect it (including attorney's fees). I authorize SPTA to release and discuss any information necessary to process claims on my behalf.

I hereby authorize SPTA to obtain or release and discuss any information produced while in treatment at SPTA from/to physicians, home health agencies or any other health care team members responsible for my past, present or follow up care.

I understand that SPTA's agreement to provide physical therapy services to me is conditioned on my signing this consent to ensure that SPTA can accomplish its professional responsibility of providing care to me.

I understand that SPTA will use and/or disclose only the minimum amount of my PHI which is necessary, in SPTA's sole judgment, for the specific needs of the recipient of for my general healthcare needs.

I ☐**do** ☐**do not** give my consent for my therapist to discuss my treatment with the following family members:
1. _____ 2. _____

With this Consent, SPTA may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist SPTA in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care. Also, subject to any applicable restrictions, SPTA may release to me copies of pertinent medical reports such as X-Ray or MRI reports that are relevant to my care, if I request them to do so.

My signature indicates consent in the event that SPTA be obliged to release and discuss to my employer any information pertinent to treatment of an employment-related compensable injury. However, release of such information is limited to said compensable injury.

We require 24-hour notice for all cancellations.

If you miss your scheduled appointment time, without giving prior notice of cancellation, a $25.00 "No Show" fee will be charged to your account. Said charge is not covered by insurance and will be the patient's responsibility.

I understand that:

- I can revoke my consent at any time prior to the release of records by delivering written, signed and dated notice of my wishes to SPTA except to the extent SPTA has acted in reliance on any consent. A decision to withdraw my consent to release records, however, may be the basis for a denial of health benefits or insurance coverage or benefits.
- I can refuse to disclose some or all of my records, but if I do so, it could result in an improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance or other adverse consequences. Partial or incomplete records will be labeled as such to inform the provider receiving them of their status.
- I can restrict SPTA's use and/or disclosure of my PHI, and that SPTA is not required to agree to my restriction, but that SPTA's agreement to such restriction is binding on SPTA.

*If I have any questions about or would like a copy of this Consent or about SPTA's privacy practices, I may ask the Office Manager.

I have reviewed and understand my rights/responsibilities as described above. Consent is valid for 30 months unless I revoke it prior to that expiration. Expires: _____ (month/day/year)

Signature: _____ **Date:** _____

Print Name: _____

Print Name of Representative: _____ **Relationship:** _____

SCARBOROUGH PHYSICAL THERAPY ASSOCIATES, P.A.
51 U.S. Route One, Scarborough, ME 04074 Telephone (207) 883-1227 Fax (207) 883-6199

PATIENT PAYMENT POLICY

At Scarborough Physical Therapy Associates we are committed to providing quality care and customer service. For your convenience, we accept cash, checks, Visa and Master Card.

The following is a statement of our Patient Payment Policy, which we ask you read and initial prior to your first appointment.

CO-PAYS

- Your insurance ***REQUIRES*** that we collect your designated co-pay at the time of service. Please be prepared to pay the co-pay at each visit.
- In the event a patient's co-pay balance exceeds $100.00, the patient must pay the balance in full or SPTA reserves the right to discontinue physical therapy services. SPTA will make every reasonable attempt toward collections and work with the patient to initiate a good faith payment plan.

DEDUCTIBLES

- Deductibles and co-insurance will be collected from the patient as directed by the Insurance Company.
- In the event the patient's balance consisting of deductible and co-insurance exceeds $250.00 the patient must pay the balance in full or SPTA reserves the right to discontinue physical therapy services. SPTA will make every reasonable attempt toward collections and work with the patient to initiate a good faith payment plan.

MISSED APPOINTMENTS

- We require 24-hour notice for all cancellations.
- If you miss your scheduled appointment time, without giving prior notice of cancellation, a $25.00 "No Show" fee will be charged to your account. Said charge is not covered by insurance and will be the patient's responsibility.

Thank you for reviewing our Patient Payment Policy. Please let us know if you have any questions or concerns.

I have reviewed and understand SPTA's Patient Payment Policy as described above. _____
Initials of Patient or Responsible Party

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SUMMARY OF "NOTICE OF PRIVACY PRACTICES"

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW IT CAREFULLY.

- Scarborough Physical Therapy Associates (SPTA) maintains the privacy of certain confidential information about you known as "Protected Health Information" (PHI). Federal and State Law require SPTA to protect your PHI and provide this Notice of Privacy Practices ("Notice"). This Notice is attached to this Summary of Notice of Privacy Practices.
- The Notice describes SPTA's duties and the privacy practices regarding your PHI.
- The Notice describes how SPTA may use and disclose your PHI to carry out treatment, payment and healthcare operations and other purposes permitted by law.
- The Notice describes when an authorization is required to use or disclose your PHI and how you can revoke your authorization. The Notice also describes when SPTA may use or disclose your PHI without your authorization.
- SPTA is committed to protect the privacy of your PHI and have instituted policies and procedures to do this.
- The Notice describes your right to access, amend and receive an accounting of the disclosures of your PHI. The Notice describes your right to request restrictions on the use and disclosures of your PHI and the right to request that we use alternative means to communicate with you.
- If you have any questions, please contact our Privacy Official June Tait, at (207) 883-1227.

ACKNOWLEDGMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

Please read the attached Notice of Privacy Practices. Please sign this Acknowledgement.

I hereby acknowledge that I have received the Notice of Privacy Practices prepared by Scarborough Physical Therapy Associates, P.A.

Name of client or legal guardian: (please print)_____

Signature: _____

Date: _____

If not signed by the Patient, please provide the following information:

Print YOUR Name:_____ Relationship to the Patient:_____

S:\June\Acknowledgment of receipt
Effective: April 14, 2003