**SCARBOROUGH PHYSICAL THERAPY ASSOCIATES, P.A.**

**PATIENT INFORMATION** **Therapist:** **Case #:** _____

**Eval Date**: _____

| **Last Name** | **First Name** | **Date of Birth** | **Primary Telephone** |
|---|---|---|---|
| **Mailing Address** | **City, State, Zip** | | **Alternate Telephone** |
| **Email Address** | | **Preferred Pronoun** | |
| **Person to Contact in Emergency** | **Relationship to Patient** | | **Emergency 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**

| Name of Policyholder/Insured | 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 | _____ | Heart/Vascular | _____ | Mouth | _____ |
| Bleeding Problems | _____ | Stomach Problems | _____ | High Blood Pressure | _____ | Breathing Problems | _____ |
| Abdominal | _____ | Hearing | _____ | Urinary | _____ | Asthma | _____ |
| Allergies | _____ | Seizures | _____ | Cancer | _____ | Vision | _____ |
| Hepatitis B | _____ | Headaches | _____ | Nose | _____ | Pacemaker | _____ |

Are you allergic to Penicillin? Yes _____ No _____ Have you ever had a reaction to Penicillin? Yes _____ No _____

Are you allergic to any other drug? Yes _____ No _____ *If so, please list:* _____

Are you currently taking any medication? *Please list:* _____

Do you have any food allergies? Yes _____ No _____ *If so, please list:* _____

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, Suite J, Scarborough, ME 04074
Telephone: (207) 883-1227 Fax: (207) 883-6199

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

I hereby authorize SPTA to administer such physical therapy procedure(s) necessary to the reasons for which I am consulting them.

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. 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.

**Email Consent:** I understand that email can be inherently insecure and may not be encrypted. I accept the risk that my protected health information may be intercepted by persons not authorized to receive such information. SPTA will not be responsible for any privacy or security breaches that may occur through email communications that I have consented to.

- □ I consent to all communication by email, including but not limited to communication about my medical condition and advice from my health care providers.
- □ I consent to email communication regarding appointments and billing only.
- □ I do not consent to any email communication.

Email address you are consenting to communicate through: _____

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 a **3-hour** prior notice of cancellation, a **$100.00 "No Show/Late Cancellation" fee** will be charged to your account. Said charge is not covered by insurance and will be the patient's responsibility. Excessive cancellations and missed appointments disrupt the consistent treatment most beneficial to a speedy recovery. **Three missed appointments, which include "No Shows" or "Late Cancellations" collectively, will result in discharge from physical therapy.**

*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.

**Signature:** _____ **Date:** _____

**Patient Name:** _____ **Case #:** _____

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

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# PATIENT PAYMENT POLICY

The following is a statement of our Patient Payment Policy, and the benefits Scarborough Physical Therapy Associates has been quoted by your Insurance Carrier. Please review, sign and date 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.

**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 $300.00 the patient must pay the balance in full or SPTA reserves the right to discontinue physical therapy services.

**CANCELLED/MISSED APPOINTMENTS**

- We require 24-hour notice for **all** cancellations.
- If you miss your scheduled appointment time, without giving prior notice of cancellation, a **$100.00 "No Show" fee** will be charged to your account. Said charge is not covered by insurance and will be the patient's responsibility.
- If you give less than a 3-hour notice of cancellation, a **$100.00 "Late Cancellation" fee** will be charged to your account. Said charge is not covered by insurance and will be the patient's responsibility.
- **Three missed appointments, which include "No Shows" or "Late Cancellations" collectively, will result in discharge from physical therapy.**

Patient Name: _____ DOB: _____ Case: _____

Primary Insurer: _____ Ins ID: _____ Grp # _____

Type of Plan: _____ Eff Date: _____

Deductible: _____ Deductible Met? _____ As of _____

Co-Insurance: _____ / _____ OOP Amt: _____ Met? _____

Co-Pay Amount: _____ Initial Eval Only _____ Per Visit _____

Maximum # of visits: _____ Per Year _____ Per Diagnosis _____ Based on Medical Necessity _____

Medical Review after: _____

# of visits used to date for this calendar/policy year: _____ As of: _____

PCP Referral Required? _____

Authorization Required? _____ Contact: _____

Prior to first visit _____ After Eval _____ After _____ Visits

IF MCR, HAS THE PATIENT RECEIVED HOME HEALTH SERVICES WITHIN 60 DAYS? Yes _____ No _____

Monetary Benefit Max/Year: _____ Monetary Amount Applied to Date: _____

**STATEMENTS**

- Statements are generated monthly, or when there is a large balance due. Payment is expected upon receipt. You may be asked for payment at your next visit.
- Once discharged, you will receive a statement as your claims process. Be advised that insurance claims can take up to 30 business days to process.

**UNPAID BALANCES AND COLLECTIONS**

- **You are responsible for all co-pays, deductibles, co-insurance amounts and any supplies you may purchase from our clinic as well as charges not covered or denied by your insurance plan**.
- Any balance that remains unpaid 60 days after your insurance company has processed all claims will be turned over to a collection agency if you have not responded to monthly billing statements. The patient is responsible for the unpaid balance and any fees, if applicable, in recovering your debt.
- We offer payment plans at the discretion of our billing department. Payments are to be made on an ongoing monthly basis. Payment plans require a monthly payment amount of 25% of the value of the debt until the debt is discharged. Balances must be paid in full prior to the start of a new plan of care.
- You can request to have regular monthly or weekly payments automatically processed by speaking with the Billing Department.

I have reviewed and understand the Patient Payment Policy at Scarborough Physical Therapy Associates as described above. ***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).***

**Signature:** _____ **Date:** _____

**Print Name:** _____ **Case #:** _____

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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.

**Signature:** _____ **Date:** _____

**Print Name:** _____ **Case #:** _____

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