PATIENT INFORMATION

Patient Name: _____ Male/Female Date of Birth: ____/_____/_____

Patient Address: _____ City: _____Zip:_____

Home Phone: _____ Cell Phone: _____

Email: _____Social Security #: _____

Spouse: _____

Employer: _____ Work Phone #: _____

Occupation: _____

Date of Injury: _____ Date of Surgery: _____

Referring Physician: _____ Primary Physician: _____

How did you hear about us? MD Referral____ Friend/Family____ Advertisement____ Other____

Person to Contact in Case of Emergency:

First and Last Name: _____ Phone: _____

If patient is a minor please provide us with the following:

Parent/Guardian name_____ Social Security # _____

Parent/Guardian employer: _____ Work #: _____

If this injury was due to a motor vehicle accident, please fill in the following:

Name of motor vehicle insurance: _____ Phone #: _____

Adjusters Name: _____ Claim #: _____

Name of insured: _____

Do you have an attorney? Yes____ No____

If yes, name: _____ Phone #: _____

Please read and initial the following statements:

_____ I hereby authorize Telos Therapy to provide treatment as prescribed by my physician.

_____ I hereby authorize the release of medical records to Telos Therapy and any pertinent information concerning the patient for the provision of care and for obtaining insurance reimbursement.

_____ I understand that I am legally responsible for payment of all services rendered by Telos Therapy. If my insurance is being billed, I well be responsible for paying co-payment and deductible amounts. I understand that co-payments are due at the time of service. I have read and understand the financial agreement (page 4).

_____ _____

Signature of Patient/Guardian Date

PATIENT HISTORY

Describe briefly the history of your present Accident, Injury, Illness or Condition:

Onset Date: _____ Description: _____

_____

List any special concerns, questions or expectations:_____

_____

_____.

Have you had <u>any physical therapy</u> during the current calendar year? _____ Have you had physical therapy for the same condition for which you are here today? _____ If yes, please indicate where and when:

_____

List **<u>ALL</u>** medications you are currently taking:_____

_____

List recent diagnostic studies (CAT scan, MRI, X-ray, ETC.) & where taken: _____

_____

Do you have METAL anywhere in your body (other than teeth), such as pins/plates, pacemaker, stints, etc.? Describe

_____

List **<u>ALL</u>** surgeries you have had; please give procedures and dates, if possible: _____

_____

_____

_____

_____

Have you ever had: (Please circle yes or no)

High blood pressure	Yes	No	Arthritis/Osteoarthritis	Yes	No
Heart disorders	Yes	No	Osteoporosis	Yes	No
High Cholesterol	Yes	No	Cancer	Yes	No
Lung Disorders	Yes	No	Pacemaker	Yes	No
Circulation disorders	Yes	No	Are you pregnant?	Yes	No
Dizzy Spells	Yes	No	Allergies to tapes or lotions?	Yes	No
Seizures	Yes	No	Tobacco use	Yes	No
Diabetes	Yes	No			

_____ _____

Signature of Patient/Guardian Date

Please provide us with a copy of your insurance cards

SUMMARY NOTICE OF PRIVACY PRACTICES

Telos Therapy is committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THE FOLLOWING CAREFULLY.

"Protected health information" is information about you, including demographic information, present or future physical or mental health or condition and related health care services. We are required by law, in most instances, to have your written consent before we use or disclose to others your medical information for the purpose of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may sometimes use or release your information without your consent or authorization as may be required or permitted by certain laws.

You have the right to the following:

- Look at and make copies of your protected health information
- Ask us to not release parts of your protected health information
- To be told when we release your protected health information
- Ask us to contact you only in certain ways
- Request us to change parts of your protected health information
- File a complaint if you think your rights have been violated

THIS IS ONLY A SUMMARY

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our notice from time to time. You have the right to obtain a copy of our most recent Notice in effect. Please ask the front desk if you wish to receive a full copy of our Notice of Privacy Practices.

If you have any questions, concerns, or complaints about the Notice or your protected health information, please contact Stefany Sarelas, PT at 312-404-1548.

My signature below indicates:

- I have been provided with the Summary Notice of Privacy Practices and I am aware that I may obtain the most recent copy of the Notice of Privacy Practice in its entirety at the front desk.
- I authorize Telos Therapy, LLC to use and disclose my health and medical information for the purposes of Treatment, Payment, and Healthcare Operations.

_____ _____

Signature of Patient/Guardian Date

FINANCIAL AGREEMENT

This is an agreement between Telos Therapy, LLC (creditor) and the Patient (debtor) named on this form.

In this agreement the words "you", "your", and "yours" mean the Patient (debtor). The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we", "us" and "our" refer to Telos Therapy, LLC.

By executing this agreement, you are agreeing to pay for all services and supplies that are received.

MONTHLY STATEMENT: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, and any payments or credits applied to your account during the month.

CONTRACTED INSURANCE: If we are contracted with your insurance company we must follow our contract and their requirements. If you have a co-pay, deductible or co-insurance, you must pay that at the time of service. As contracted providers with your insurance company, we agree to accept the allowable amount (usual and customary) established by your insurance company. Although we may estimate what your insurance company may pay and the patient responsibility portion, it is the insurance company that makes the final determination of payment and eligibility.

NON-CONTRACTED INSURANCE: Insurance is a contract between you and your insurance company. It is the patient's responsibility to verify if our office is a contracted or non-contracted provider. As a non-contracted provider, there is no adjustment or write-off for the difference between what we charge and what the insurance allows. You agree to pay any portion of the charges not covered by your insurance.

PRIMARY INSURANCE: If possible, we will verify your insurance benefits and eligibility prior to your first appointment. It is the patient responsibility to be aware of your own benefits and eligibility. If your insurance company notifies us that they are waiting to receive the accident report form from you, the balance is automatically patient responsibility and we will begin collection procedures. As a courtesy to you, we will bill your primary insurance; however, if our office has not received payment after 120 days, the balance will become patient responsibility unless other arrangements are made with us.

WORKERS' COMPENSATION: If your claim is in deferred status, we will ask for private medical insurance to bill if your claim is denied. We require approval / authorization by worker's compensation carrier prior to your initial visit. If your claim is denied and you do not have private medical insurance, you will be responsible for payment in full. If your claim is in litigation, we do require verification of this from your attorney and/or worker's compensation carrier.

PERSONAL INJURY / MOTOR VEHICLE ACCIDENTS (MVA): If you are being treated as part of a personal injury lawsuit or claim, we may require verification from your attorney. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred in a personal injury case. If you have Personal Injury Protection (PIP) through your motor vehicle insurance, we will bill them as primary insurance and will bill your private health insurance when your PIP benefits are depleted.

BILLING INFORMATION: It is your responsibility to provide us with correct information including insurance, responsible party, date of injury, type of accident, policy and/or group numbers, etc. Should the information change, it is your responsibility to update it within a timely manner. If you supply us with incorrect information, the balance of the account at the last date of service will be entirely patient responsibility. We will not be responsible for rebilling, appealing or other dealings with newly provided insurance company.

METHODS OF PAYMENT: We accept VISA, MasterCard, personal checks and cash. There is a fee of $25 for any checks returned by your bank.

PAST DUE ACCOUNTS: If your account becomes past due, we may need to take necessary steps to collect this debt. This may include contacting the person listed as the Emergency Contact on your patient data sheet. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred.

MISSED APPOINTMENT FEE: A $25 fee may be charged for appointments cancelled with less than 24 hours notice. A $50 fee will be charged for no show or missed appointments. This fee must be paid before a new appointment is made. This fee is not billable or payable by insurance.

INSURANCE BENEFITS:
Patient Responsibility

_____ Deductible

_____ Copay/Coinsurance