New Patient Information Sheet

Welcome to our practice!

Achieve Bracing

Please help us serve you better by taking a few minutes to provide the following information.

PATIENT INFORMATION

Title	Last Name	First Name	MI	Social Security #	Patient Account #

Street Address (Road or Street)	(Apartment Number or Second Address Line)

City	Zip Code	State

Home Phone:	Cell Phone:	Patient Data: (Nick Name)

Birthday	Sex (M, F)	Referring Doctor full name

Marital	Employment	Student	Relationship to Insured
☐ Married	☐ Full	☐ Full	☐ Self
☐ Widowed	☐ Part	☐ Part	☐ Spouse
☐ Single	☐ Retired	☐ None	☐ Other
☐ Divorced	☐ None		☐ Child
☐ Separated			

Employer Name

Employer Street Address (Road or Street)

City	State	Zip Code	Business Phone	Ext

COMPLETE IF INSURANCE IS IN SPOUSE'S/PARENT NAME

Title	Last Name	First Name	MI	Social Security #

Birthday	Sex (M, F)	Relationship to Insured:

ACCIDENT DETAILS- Please complete if visit is due to injury

Employment related:	Accident Related:	Date of first symptom or accident:
☐Yes ☐No	☐Auto ☐Other ☐No	

Give Details of Accident:

I authorize the release of any medical or other information necessary to process insurance claims.	I authorize payment of medical benefits directly to this practice for the services rendered.
Signed Date	Signed Date

Front Office Initials _____

CONSENT TO TREAT AND CONDITIONS OF ADMISSION

1. CONSENT TO REHABILITATION PROCEDURES: The undersigned consents to the procedures which may be performed during this and future outpatient physical therapy visits that are performed at Achieve Health and Wellness.
2. LEGAL RELATIONSHIP BETWEEN ACHIEVE HEALTH AND WELLNESS PHYSICAL THERAPISTS: All Physical Therapists, and Physical Therapist assistants are employed by Achieve Health and Wellness, Inc.
3. RELEASE OF INFORMATION: Upon inquiry and to the extent allowed by law, Achieve Health and Wellness may make available certain basic information about the patient in accordance with HIPPA regulations, including name, address, age, sex, general description of the reason for treatment (whether an injury, burn, poisoning or other condition) general nature of the injury, burn, poisoning or other condition, and general condition. If the patient's representative does not want such information to be released, he/she must make a written request for said information to be withheld. The patient or his/her representative may present a written request to Achieve Health and Wellness for this purpose. The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, Achieve Health and Wellness may disclose portions of the patients record including his/her medical record, to any person or entity which is or may be liable for all or any portion of Achieve Health and Wellness's charges, including but not limited to government agencies (e.g., Medicare, Medicaid, insurance companies, health care service plans, or workers compensation carriers). By signing below, I acknowledge that I have received Achieve Health and Wellness's Notice of Privacy Practices.
4. FINANCIAL AGREEMENT: The undersigned agrees whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of Achieve Health and Wellness in accordance with the regular rates and terms of Achieve Health and Wellness. All accounts are handled by an independent billing company, including billing, collections and all other matters relating to the account.
5. ASSIGNMENT OF INSURANCE BENEFITS: The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to Achieve Health and Wellness of any insurance or other applicable (e.g., Medicare, Medicaid) benefits otherwise payable to or on behalf of the undersigned or patient for these outpatient services, at rate not to exceed Achieve Health and Wellness's regular charges. It is agreed that payment to Achieve Health and Wellness, pursuant to the authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. Any pre-certification of insurance benefits is the patient's sole responsibility. The undersigned authorizes payment of Medicare/Medicaid benefits to be made on behalf of the patient for all services furnished by Achieve Health and Wellness. It is further understood by the undersigned that he/she is financially responsible for charges not collected by this agreement, unless otherwise stated by applicable written contract or law.
6. AUTHORIZATION FOR RELEASE OF INFORMATION AND FOR PAYMENT:

I hereby authorize the release of all information from the patient's medical record that may be necessary to make reimbursement or payment for any or all the services rendered by the Therapist involved in my care with Achieve Health and Wellness. I hereby authorize my Insurer or any third party responsible for the payment of covered medical/surgical benefits on my behalf to make payment directly to Achieve Health and Wellness. As a patient I understand that I am responsible for my insurance benefits and understand my in network and out of network coverage.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patients general agent to execute this document and accept and agree to its terms.

_____ _____

Patient / Guardian Signature Date

_____

Print Patient Full Name

Front Office Initials _____

FINANCIAL POLICY

As a courtesy to our patients, we check the insurance coverage and benefits for therapy services; however, it is the patient's responsibility to verify coverage, understand their particular insurance and insure that payment is made.

Therapy services are billed on time based procedure codes. Your therapist will perform a variety of activities with you in order to maximize your recovery and help you to reach your goals. The therapist will choose the appropriate charge codes based on the activities that are performed and how much time is spent on each procedure or activity.

In the information below, we are ESTIMATING the amount of money you will need to pay after you insurance has been filed. The information below does not guarantee insurance coverage or insurance payment. When insurance benefits are verified, the insurance company does not guarantee payment. If the insurance company denies coverage, you will receive a bill for those services.

Achieve Health and Wellness does not accept third party liability insurance. If you have been involved in an accident where there is third party coverage, you will be responsible for paying for therapy services rendered by Achieve Health and Wellness at the time that services are rendered and collecting from the third party.

The amount not covered by the primary insurance company is ESTIMATED below. That amount is payable on the date that services are rendered. This estimate is determined by benefits from your plan or from a predetermination from your insurance company. Please understand that this is only an estimate and that insurance companies have their own schedule of what they consider to be "usual and customary". These fees often vary between plans. Our charges are based solely on the amount of time, skill and care that is provided by your therapist for each individual treatment session. Therefore, it is not uncommon to find a difference in our charges and the insurance payment. If we are in network for your insurance carrier, you will be responsible for the insurance allowable. If we are not in network for your insurance, you will be responsible for the difference between the allowable and the charge. Please understand that your insurance is an agreement between you, your employer and the insurance carrier.
PAYMENT IS DUE AT THE TIME THAT SERVICES ARE RENDERED.

The information below is provided as a courtesy to you but is an ESTIMATE of your insurance benefits and does not guarantee insurance payment. If you have NOT met your deductible, we will take a deposit from you towards your deductible at each visit until you meet the deductible. You will receive a bill for the difference between the deposit and the insurance allowable after the insurance has communicated the allowable. If you have had a recent procedure that should apply to your deductible, it may not have been billed by the hospital or physician's office and therefore, may not be listed when we checked your benefits. If you have a co-insurance percentage that you are expected to pay, we will collect an estimated amount on that co-insurance and you will receive a bill for the difference between what you paid and what the insurance company allows. **We encourage you to contact your insurance company to better understand your benefit for therapy services.**

☐We ARE contracted with your insurance company
☐We are NOT contracted with you insurance company
☐Your individual deductible is $_____
☐Your co-pay for each visit is $_____
☐You have met $_____ of your individual deductible
☐You are responsible for a co-insurance of ____percent
☐Your family deductible is $_____
☐We require a payment of $_____ towards that coins. per visit
☐You have met $_____ of your family deductible
☐Your total out of pocket is $_____
We require a payment of $_____ towards your deductible
☐You have met $_____ of your total out of pocket expenses

☐Your insurance allows $_____for therapy each benefit year. We estimate that to be _____ visits. This does not guarantee this number of visits, but this is an estimate to assist you in making decisions regarding your therapy.
☐Your benefits allow you _____ PT/OT visits each benefit year.
☐Your insurance requires precertification and has authorized _____ visits. Pre-certification Expires on _____
☐Your benefits are pending because: _____

I have read the information above and understand that I am responsible for payment of therapy services not covered by my insurance policy.

x_____ _____
Patient / Guardian Signature Date

Front Office Initials _____

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 IT CAREFULLY.

Your health information is personal, and we are committed to protecting it. Your health information is also very important to our ability to provide you with quality care, and to comply with certain laws. This Notice applies to all records about your care that occurs at any of our Achieve Health and Wellness facilities. This Notice applies to all records about your care at our facilities or affiliated entities.

HIPAA does not apply to information disclosed in connection with a worker's compensation matter. Pursuant to law, your health information relevant to a worker's compensation matter will be disclosed to your employer's workers compensation insurer or third party administrator and to your employer.

I. We Are Legally Required to Safeguard Your Protected Health Information. We are required by law to:

A. maintain the privacy of your health information, also known as "protected health information" or "PHI;"

B. provide you with this Notice, and

C. comply with this Notice.

II. Future Changes to Our Practices and This Notice. We reserve the right to change our privacy practices and to make any such change applicable to the PHI we obtained about you before the change. If a change in our practices is material, we will revise this Notice to reflect the change. You may obtain a copy of any revised Notice by contacting 406 Roy Martin Rd Suite #9 Gray, TN 37615. We will also make any revised Notice available in our clinics.

III. How We May Use and Disclose Your Protected Health Information. The law requires us to have your written authorization to some uses and disclosures. In other circumstances, the law allows us to use or disclose PHI without your written authorization. This Section gives examples of each of these circumstances.

A. Uses and Disclosures for Treatment, Payment and Health Care Operations. We may use or disclose your PHI to provide treatment to you. For example, we may disclose your PHI to physicians, nurses, and other health care personnel who are involved in your care. We may also use and disclose your PHI to contact you as a reminder that you have an appointment for treatment at our facility, to tell you about or recommend possible treatment options or alternatives, or about health-related benefits or services that may interest you.

We may also use or disclose your PHI to your insurance carrier in order to get paid for treatment provided to you. For example, we may use your PHI to create the bills that we submit to the insurance company, or we may disclose certain portions of your PHI to our business associates who perform billing and claims processing services to us.

We may also use or disclose your PHI in order to operate this facility. For example, we may use your PHI to evaluate the quality of care you received from us, or to evaluate the performance of those involved with your care. We may also provide your PHI to our attorneys, accountants and other consultants to make sure we are complying with the laws that affect us.

B. Uses and Disclosures That Require Us to Give You the Opportunity to Object. If you do not object, we may include your name and location in our facility in the patient directory that we use when responding to requests by those who ask for you by name. Unless you object, we may provide relevant portions of your PHI to a family member, friend or other person you indicate is involved in your health care or in helping you get payment for your health care. In an emergency or when you are not capable of agreeing or objecting to these disclosures, we will disclose PHI as we determine is in your best interest, but will tell you about it later, after the emergency, and give you the opportunity to object to future disclosures to family and friends. Unless you object, we may also disclose your PHI to persons performing disaster relief notification activities.

C. Certain Uses and Disclosures Do Not Require Your Written Authorization Other than Uses and Disclosures for Treatment, Payment and Health Care Operations. The law allows us to disclose PHI without your written authorization in the following circumstances:

(1) When disclosure is required by federal, state, or local law; judicial, board, or administrative proceedings; or law enforcement.

(2) If disclosure is compelled by a party to a proceeding before a court of an administrative agency pursuant to its lawful authority.

(3) If disclosure is required by a search warrant lawfully issued to a governmental law enforcement agency.

(4) If disclosure is compelled by the patient or the patient's representative pursuant to Health and Safety Codes or to corresponding federal statutes of regulations, such as the Privacy Rule that requires this Notice.

(5) To avoid harm, PHI may be provided to law enforcement personnel or persons able to prevent or mitigate a serious threat to the health or safety of a person or the public.

(6) If disclosure is compelled or permitted by the fact that you are in such mental or emotional condition as to be dangerous to yourself or the person or property of others, and if I determine that disclosure is necessary to prevent the threatened danger.

(7) If disclosure is mandated by the Child Abuse and Neglect Reporting law if there is a reasonable suspicion of child abuse or neglect.

(8) If disclosure is mandated by the Elder/Dependent Adult Abuse Reporting law if there is a reasonable suspicion of elder abuse or dependent adult abuse.

(9) If disclosure is compelled or permitted by the fact that you tell me of a serious/imminent threat of physical violence by you against a reasonably identifiable victim or victims.

(10) If disclosure is compelled or permitted by the fact that you report the commission of or contemplation of a commission of a crime.

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(11) For public health activities.

(12) For quality review health oversight activities.

(13) For specific government functions which impact national security, or veterans or military personnel.

(14) For research purposes which may result in improved practices.

(15) For Workers' Compensation compliance purposes.

(16) If an arbitrator or arbitration panel compels disclosure.

(17) If disclosure is required or permitted to a health oversight agency for oversight activities authorized by law, such as HIPAA compliance.

(18) If disclosure is otherwise specifically required by law.

For some types of PHI, there may be stricter restrictions on our use or disclosure of PHI. For example, drug and alcohol abuse patient treatment information, HIV test results, mental health information, and genetic testing results may be subject to greater protection of your privacy.

In general, we may disclose a minor patient's PHI to a parent or guardian, but we may deny the parents' access to the minor patient's PHI in some situations.

IV. Other Uses and Disclosures of Your Protected Health Information. Other uses and disclosures of your PHI that are not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us written authorization for a use or disclosure of your PHI, you may revoke that authorization, in writing, at any time. If you revoke your authorization we will no longer use or disclosure your PHI for the purposes specified in the written authorization, except that we are unable to take back any disclosures we have already made with your permission, and are required to retain certain records of the uses and disclosures made when the authorization was in effect.

V. Your Rights Related to Your Protected Health Information. You have the following rights:

A. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask us to limit how we use and disclose your PHI, as long as you are not asking us to limit uses and disclosures that we are required or authorized to make to the Secretary of the federal Department of Health Services, related to our facility's patient directory, or any of the disclosures described in Section III, above. Any such request must be submitted in writing to our Privacy Officer.
We are not required to agree to your request. If we do agree, we will put it in writing and will abide by the agreement except when you require emergency treatment.

B. The Right to Choose How We Communicate With You. You have the right to ask that we send information to you at a specific address (for example, at work rather than at home) or in a specific manner (for example, by e-mail rather than by regular mail, or never by telephone). We must agree to your request as long as it would not be disruptive to our operations to do so. You must make any such request in writing, addressed to our Privacy Officer.

C. The Right to See and Copy Your PHI. Except for limited circumstances, you may look at and copy your PHI if you ask in writing to do so. Any such request must be addressed to Medical Records, which will respond to your request within 30 days (or 60 days if the extra time is needed). In certain situations we may deny your request, but if we do, we will tell you in writing of the reasons for the denial and explain your right to have the denial reviewed.
If you ask us to copy your PHI, we will charge you $25.00 processing fee and $.65 per page

D. The Right to Correct or Update Your PHI. If you believe that the PHI we have about you is incomplete or incorrect, you may ask us to amend it. Any such request must be made in writing and must be addressed to our Medical Records, and must tell us why you think the amendment is appropriate. We will not process your request if it is not in writing or does not tell us why you think the amendment is appropriate. We will act on your request within 60 days (or 90 days if the extra time is needed), and will inform you in writing as to whether the amendment will be made or denied. If we agree to make the amendment, we will ask you who else you would like us to notify of the amendment.

We may deny your request if you ask us to amend information that:

(1) was not created by us, unless the person who created the information is no longer available to make the amendment; (2) is not part of the PHI we keep about you; (3) is not part of the PHI that you would be allowed to see or copy; or (4) is determined by us to be accurate and complete.

If we deny the requested amendment, we will tell you in writing how to submit a statement of disagreement or complaint, or to request inclusion of your original amendment request in your PHI.

E. The Right to Get a List of the Disclosures We Have Made. You have the right to get a list of instances in which we have disclosed your PHI. The list will not include disclosures we have made for our treatment, payment and health care operations purposes, those made directly to you or your family or friends or through our facility directory, or for disaster notification purposes. Neither will the list include disclosures we have made with your written authorization, for national security purposes or to law enforcement personnel, disclosure of limited data set, or disclosures made before April 14, 2003.

Your request for a list of disclosures must be made in writing and be addressed to our Medical Records. We will respond to your request within 60 days (or 90 days if the extra time is needed). The list we provide will include disclosures made within the last six years unless you specify a shorter period. The first list you request within a 12-month period will be free. You will be charged our costs for providing any additional lists within the 12-month period.

F. The Right to Get a Paper Copy of This Notice. Even if you have agreed to receive the Notice by e-mail, you have the right to request a paper copy as well. You may obtain a paper copy of this Notice by contacting 406 Roy Martin Rd Suite #9 Gray, TN 37615. The Notice is also available in our clinics.

VI. Complaints. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the federal Department of Health and Human Services. To file a complaint with us, put your compliant in writing and address it to our Owner/President . We will not retaliate against you for filing a complaint. You may also contact our Owner/President if you have questions or comments about our privacy practices.

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