Patient Information

Excel Physical Therapy

810 Mallet Hill Road
Suite 2
Columbia, SC 29223
(P) 803.661.8522
(F) 803.419.6692

Please check claim type:

( ) Workers Compensation ( ) Health Insurance ( ) Self Pay ( ) Personal Injury/Attorney

Patient Information:

Last Name: _____ First Name: _____ ( ) male ( ) female

Mailing Address: _____

City: _____ State: _____ Zip: _____

Primary #: _____ (H): _____ (W): _____

(Cell): _____ May we text appointment reminders? Yes No Leave Voicemail? Yes No

Email Address: _____ May we email appointment reminders? Yes No

SS#: _____ Date of birth: _____

In case of emergency, contact: _____ Relationship: _____ Phone: _____

Employer: _____ Occupation: _____

Employer's Address: _____

Contact person: _____ Phone: _____

Has a claim been filed to the workers compensation carrier? ( ) yes ( ) no

Primary insurance: _____

Policy #: _____ Group #: _____

Policy holder's name: _____ Date of birth: _____

What is your relationship to policyholder? ( ) self ( ) spouse ( ) child ( ) other

Secondary insurance: _____

Policy #: _____ Group #: _____

Policy holder's name: _____ Date of birth: _____

What is your relationship to policyholder? ( ) self ( ) spouse ( ) child ( ) other

Type of Injury: _____ Date of Injury: _____

By my signature below, I hereby authorize the release of medical information needed to process my claim through my insurance company. I authorize my insurance benefits to be paid directly to Excel Physical Therapy and agree that I am financially responsible for any amounts not covered and/or paid by them. It is the policy of this office to collect charges for services as they are rendered, unless prior arrangements are made and credit is established. Insurance patients are responsible for paying their co-payments and deductible at the time services are rendered. I hereby authorize such treatment as is necessary and to perform medical treatment on the basis of findings during the course of said treatment. I hereby certify that I have read and fully understand the above authorization for treatment, the reason the above named treatment is considered necessary the advantages and possible complications, if any, as well as possible alternative modes of treatment which were explained to me. I also certify that no guarantee or assurance had been made as to the results that may be obtained.

Signed: _____

Date: _____

Responsible party signature (if different from above): _____

Notice of Privacy Practices

Excel Physical Therapy

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This Notice describes how medical information about you may be used and disclosed and how you can get access to this information.

This Notice describes the Privacy practice of Excel Physical Therapy.

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment and related medical information. Your health information also includes payment, billing and insurance information.

How We Use Your Patient Health Information

We use health information about you for treatment, to obtain payment for administrative purposes, for evaluation of the quality of care, and so forth. Under some circumstances, we may be required to use or disclose information even without your consent.

Treatments: We will use and disclose your health information to provide you with medical treatment or services. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, to laboratories performing tests, and to family members who are helping with your care, and so forth.

Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payment from your health plan.

Administrative: We may ask you to complete a sign-in sheet or staff members may ask you the reason of your visit so we can better care for you. Despite safeguards, it is always possible in a doctor's office that you may learn information regarding other patients or they may inadvertently learn something about you. In such cases, we expect our patients to maintain strict confidentiality.

We may use and disclose your health information to perform various routine functions (e.g. quality evaluations or records analysis).

We may use your information to contact you. We may also contact you to provide information about referrals for follow-up, with lab results, to inquire about your health, or for other reasons.

Special Situations

We may use or disclose identifiable health information about you for other reasons, even without your permission.

Legal: We may be required by law to report gunshot wounds, suspected abuse or neglect, and so on: we may be required to disclose vital statistics, diseases, and similar information to public health authorities; we may be required to disclose information for audits and similar activities. In response to a subpoena or court order, or as required by law enforcement officials.

We may release information about you for workers compensation or similar programs, we may disclose information to protect your health or the health of others or for legitimate government needs, for approved medical research, or to certain entities in cases of death.

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In some situations, we may ask for your written authorization before using or disclosing any identifiable health information about you, if you sign an authorization; you can later revoke that authorization.

Individual Rights

You have certain rights with regard to your health information, for example:

You may request restrictions on certain uses and disclosures of your health information, though we are not required to agree to such restrictions.

You may ask us to communicate with you confidentially by, for example, sending notices to a special address.

In most cases, you have the right to get a copy of your health information. there will be a charge for copies.

If you believe information in your record is incorrect, or if important information is missing, you have the right to request that we amend the existing information.

You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or administration. There may be a charge for this information.

Our Legal Duty

We are required by law to protect and maintain the privacy of your health information, to provide this notice about our legal duties and privacy practices regarding health information, and to abide by the terms of the Notice currently in effect.

We may update or change our privacy practices and policies at any time. Before we make a significant change in our policies, we will change our Notice and prost the new Notice in the admissions area. You can also request a copy of our Notice at any time.

If you are concerned about your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed. You also may send a written complaint to the US Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

Contact

If you have questions, request, or complaints, please contact:

Excel Physical Therapy
Attn: Heather Reeves, MSPT
810 Mallet Hill Road
Columbia, SC 29223
803.661.8522

HIPPA South Carolina
US DHHS
Atlanta Federal Center
Suite 3870
81 Forsyth Street
Atlanta, FA 30303-8900
404-582-7888

Patient Acknowledgement
1. I understand that a patient's health information is private and confidential. I understand that Excel Physical Therapy has procedures to protect a patient's privacy and preserve the confidentiality of every patient's personal health information. I will assist by following these procedures. I choose to exercise any of my rights described in the "Notice of Privacy Practices."

2. This patient acknowledgement will become part of my permanent record. I further acknowledge that should I become aware of any Patient's private health matters, I will not disclose them to others, and I will treat any such knowledge as strictly confidential and private.

3. My signature verifies that I understand how Excel Physical Therapy may use my patient information, that I have read the "Notice of Privacy Practices", and I agree to be seen and treated under the stipulation as described.

_____
Patient's Name

_____
Date of Birth

_____
Social Security Number

_____
Signature

_____
Witness

_____
Today's Date

Consent for Care and Medical Treatment

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I, the undersigned, do hereby agree and give my consent for **Excel Physical Therapy** to furnish Physical Therapy services to _____(patient name)_ and is considered necessary and proper in treating his/her physical condition.

_____
Signature

_____
Date

FINANCIAL POLICY STATEMENT

We will submit your physical therapy claims to your insurance carrier each day that treatment is provided as a courtesy to you. Your insurance company and/or Medicare has developed maximum fee schedules for rehabilitation and other services that **may** or **may not** cover all charges incurred during your treatment.

Please be advised that you are responsible for the total charges or any remaining balance following payment by your insurance company. If you do not feel your insurance company has made adequate payment, please contact them to discuss this matter.

The above does not apply for those patients that are under the care of 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.

The above information has been read and explained to me. I understand my responsibility for the payment of my account.

_____
Signature

_____
Date

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RELEASE OF INFORMATION

Patient Name: _____

Date of birth: _____

The following people are allowed to receive information, other than myself:

		Medical	Financial	Appts
1.	_____	___	___	___
	Relationship to pt: _____			
2.	_____	___	___	___
	Relationship to pt: _____			
3.	_____	___	___	___
	Relationship to pt: _____			

May we call and leave a voicemail message? Yes No

If yes, what number? _____ about? ___ ___ ___

May we send a text to this number? Yes No

May we send an email message? Yes No about? ___ ___ ___

Current email address: _____

_____ _____

Patient Signature Date

MEDICINE LIST

Date: _____

Patient Name: _____ Date of birth: _____

Allergies: _____

_____

	Name of Medicine	Strength	How taken	What is this medicine for
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

_____ _____

Physical Therapist Date Reviewed

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TELEHEALTH SERVICES *(optional)*

Excel Physical Therapy will now offer Telehealth services to patients in conjunction with physical care provided in the clinic. We realize it is not always feasible for you to attend your Physical Therapy sessions due to work, illness, or family obligations. Our goal is to bridge any gap in your care by providing with exercise progressions that will enhance your rehabilitation experience with us. If this is something you may be interested in, please provide us with the information that follows and we will discuss this component of care at your initial evaluation with us in the clinic.

E-mail address: _____

Phone Number: _____

May we send you text messages? Yes No

To opt out, check here: ____

To consent to these services,

Patient Signature: _____ Date: _____