WELCOME TO SPORTS CONDITIONING AND REHABILITATION

We are pleased you have chosen *SPORTS CONDITIONING AND REHABILITATION, (SCAR)* for your physical therapy needs. We know there are many choices and we appreciate your confidence in us.

You will find we provide unsurpassed individualized patient care in a warm caring and professional environment. At SCAR, we are uniquely qualified to help you move through the full continuum of wellness from rehabilitation of your injury or disability to the promotion of injury prevention and leading a full healthy lifestyle.

To make the most of your physical therapy experience, we have provided you with all the information you will need to make your time with us the best it can be.

Please take the time to read ***all*** of our attached policies and fill out the following form(s) completely ***prior*** to your scheduled appointment. *You are responsible for knowing all of the information in our policy pages*.

On the day of your appointment, please bring the following:

- Completed form(s)
- Insurance Card
- Identification Card (Drivers License)
- Referral for Physical Therapy

Arriving 20 minutes early will give us the time we need to go over your paper work as well as collect the last couple items we will need from you and be ready for your appointment. If you need to fill out your paperwork at SCAR, please allow at least 30 minutes prior to your scheduled appointment. To better serve you, please observe the following guidelines and policies so we at SCAR can provide you with the highest quality of care and service.

- *Schedule your appointments ahead of time for the entire treatment plan that your physical therapist has prescribed for you to ensure you get a time that works well in your day.*
    - Our physical therapy hours are 7:00 am to 8:00 pm Monday - Friday and 9:00 am to 1:00 pm Saturday
    - Upon your arrival, you will need to check in with the front desk staff.
- *Please be on time.*
- *Please place your cell phones on silent or vibrate and put in a pocket or purse.*
- *Dress for Exercise.*
    - Be prepared to exercise and move easily with loose fitting, comfortable clothing. If needed, we do have a locker room to change or shower and store your clothes. Please bring your own lock for the locker.

We greatly appreciate your adherence to our guidelines and especially to you as our patient, and strive to accomplish wonderful results and success for you.

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NEW PATIENT INFORMATION

Appointment Date:_____ Who referred you to SCAR?_____

Time:_____ Was this the first time you heard of SCAR? Y_____ N_____

Therapist::_____ If no, where?_____

PATIENT INFORMATION

Patient Name:_____ Home Phone:_____

Date of Birth:_____ SSN_____ Cell Phone:_____

Address:_____ Work Phone:_____

Street Email:_____

_____ _____ _____ Best time and place to reach you:_____

City State Zip Contact preference: Email___ Phone___Text____

Sex: M F Marital Status:_____ *IN CASE OF EMERGENCY CONTACT*

Patient Employer/School_____ Name:_____

Address:_____ Relationship_____

Responsible Party:_____ Home Phone:_____

Relationship:_____ Cell Phone:_____

Employer Address:_____ *REFERRING PHYSICIAN*

RESPONSIBLE PARTY INFORMATION Name:_____

Primary Insurance Phone:_____

Insurance Company:_____ Fax:_____

Telephone:_____Group #_____ Address:_____

Name of Insured:_____ID#_____ _____

Driver's License:_____SSN_____

Has the patient had home health? Y_____N_____ Is this injury due to an accident: Y_____N_____

Do you have a Secondary Insurance? Y_____N_____ Type of Injury: Auto_____Work_____Other___

Insurance Company:_____ Date of Injury:_____

Telephone:_____ Group #_____

AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

I grant permission for all physical therapy treatment and procedures deemed necessary by my physician and set forth by my physical therapist.

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to Sports Conditioning and Rehabilitation.

_____ _____

Patient/Guardian Signature: Date:

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HEALTH HISTORY

PATIENT #

Patient Name:	Birth date:	Date:
Chief Complaint:		

History of Present Injury:

Severity (How severe is the pain/problem on a scale of 1-10)	*Duration* (How long have you been having this pain/problem?)
Timing (Does the pain/problem occur at a certain time?)	*Context* (Where were you at the onset of this pain/problem?)
Location (Where is the pain/problem?)	*Quality* (Normal vs. abnormal activity, etc)
Associated signs/symptoms (Other associated problems?)	*Modifying factors* (What makes the pain/problems worse/better?)

Past Medical History:

Have you ever had the following? Circle N or Y or leave blank if uncertain

Measles	N	Y	Anemia	N	Y	Epilepsy	N	Y	Hepatitis	N	Y
Mumps	N	Y	High Blood Pressure	N	Y	Back Trouble	N	Y	Ulcer	N	Y
Chickenpox	N	Y	Low Blood Pressure	N	Y	Tuberculosis	N	Y	Arthritis	N	Y
Whooping Cough	N	Y	Migraine Headaches	N	Y	Last Chest X-ray			Pneumonia	N	Y
Scarlet Fever	N	Y	Cancer	N	Y	Asthma	N	Y	Please list any other problems:		
Diphtheria	N	Y	Polio	N	Y	Hives or Eczema	N	Y			
Smallpox	N	Y	Glaucoma	N	Y	AIDS or HIV	N	Y			
Thyroid Disease	N	Y	Hernia	N	Y	Infectious Mono	N	Y			
Rheumatic Fever	N	Y	Blood Transfusions	N	Y	Bronchitis	N	Y			
Mitral Valve Prolapse	N	Y	Bleeding Tendency	N	Y	Heart Disease	N	Y			
Kidney Disease	N	Y	Diabetes	N	Y	Stroke	N	Y			

Previous hospitalizations/surgeries/serious illnesses

Medications: (include non-prescriptions)

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in my medical status.

Signature of Patient, Parent, Guardian: **Date:**

Therapist Review:

Therapist Signature: : Date:

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FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing Sports Conditioning and Rehabilitation as your health care provider. We are committed to providing you with a successful physical therapy experience. The following is a statement of our Financial Policy and your agreement to follow our policy, which we require you to read and sign prior to your Physical Therapy evaluation or treatment. Our front office staff will give you an estimate of how much each visit will be once we've received your insurance information. *PLEASE PROTECT YOURSELF, WE ENCOURAGE YOU TO CHECK WITH YOUR INSURANCE CARRIER(S) AND KNOW YOUR POLICY WITH REGARDS TO PHYSICAL THERAPY PRIOR TO YOUR FIRST APPOINTMENT.*

PRIVATE INSURANCE PLANS: Please provide us with a copy of your insurance card and ID. All charges for services incurred by you, our patient, are your responsibility and will be expected to be paid in full. We will be more than happy to verify your insurance benefits and submit claims to your insurance company as a courtesy to you. However, it is your responsibility to know your co-payments, co-insurance, deductible and coverage.

Initial:_____

DEDUCTIBLES AND CO-PAYMENTS must be made at each visit. It is our policy to collect a percentage of each visit or the entire fee until a deductible has been reached. "It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments." This is mandated by the federal government.

Initial:_____

OUT-OF-NETWORK INSURANCE PLANS: An out-of-network provider is one which has not contracted with your insurance company for reimbursement at a negotiated rate. Insurance plans do offer coverage for out-of-network providers. We will be more than happy to verify your insurance benefits and submit claims to your insurance company as a courtesy to you. However, it is your responsibility to know your co-payments, co-insurance, deductible and coverage. If payment from your insurance company is sent to you, it is your responsibility to either sign the checks over to SCAR, or to pay SCAR directly.

Initial:_____

MEDICARE: Medicare is the federal health insurance program for people who are 65 or older, certain younger people with disabilities or disease. We do accept Medicare patients; however, this does not mean that Medicare pays your bill in full. We will be more than happy to verify your Medicare and secondary insurance benefits and submit your insurance claims as a courtesy to you. Medicare patients must pay their yearly deductible and are responsible for any portion that their secondary does not cover. Effective January 2016, Medicare only allows $1,960.00 per year for physical therapy treatment. There are some exceptions for certain diagnosis codes. Please check with the billing department to see if your diagnosis falls under the exceptions outlined by Medicare. Anything over this amount is the responsibility of the patient, if the secondary does not pick up the charges.

Initial:_____

CASH/COLLECTION POLICY: Our charges vary depending on the complexity of the diagnosis, the amount of procedures needed for your rehabilitation, the time required for your therapy sessions and the amount of reimbursement from your insurance company. Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. ***For patients without insurance coverage, or those who have exhausted their physical therapy benefits***, we offer a cash discount if paid at the time of service. We provide this option to make your healthcare accessible and affordable. If you choose to purchase medical equipment or supplies, please understand these items are ***not returnable***, and payment is expected at the time of purchase.

INTIAL EVALUATION	$125-150
THERAPY CHARGES per visit	$75-125

ACCOUNT BALANCES: Please be advised that returned checks and balances older than 30 days from your treatment discharge may be subject to additional collection fees, as well as, interest charges of 1.6% per month. Initial:_____

We must emphasize that as a medical provider, our relationship is with you, not your insurance company

I,_____, understand that ***I am financially responsible for all insurance benefits that are deemed not medically necessary and/or eligibility that is not approved by my Health Insurance Plan***, pertaining to all charges related to services provided to me or my dependents.

_____ _____

Patient/Guardian Signature Date

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SPORTS CONDITIONING AND REHABILITATION PAYMENT POLICY

Our office policy states all co-pays, co-insurance and deductible payments are due at the time of service. If not paid at the end of the week of service, all unpaid co-insurance and deductible payments will be collected using the information provided below unless other arrangements are made with the SCAR front office staff. Our policy is in accordance with the guidelines of individual insurance carriers which states that patients are responsible for paying co-insurance and deductible payments at the time of each visit. (Please see attached letter for more details.)

Our payment policy is perfectly compatible with all insurance contracts, as no unusual payments are asked for at the time of the visit. We ask that you pay by cash or check each visit, or arrange to have a credit card charged at the end of each week.

When you receive your explanation of benefits (EOB), we will charge you for any remaining balances that are outstanding and owed by you, the patient.

This information will be input into our secure online server and encrypted. No paper copy will be available in our office. Our office will use this information for collection purposes only.

We appreciate your understanding and cooperation.

Sincerely,

Jim Herkimer, MS, MPT, ATC
President/CEO

Patient Name:_____

- ☐ MASTERCARD
- ☐ VISA
- ☐ Discover

Credit Card Number:_____-_____-_____-_____Exp. Date:____/____/_____ CV Code_____

Name as it appears on the credit card:_____

Signature:_____Date:____/____/_____

☐ ID checked by SCAR Office Staff (CDL expires_____)

I agree to the above payment policy and do take full responsibility for my co-payments and all payments which are applied to my deductible.

_____

Patient (or Responsible Party) Signature

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APPOINTMENT CANCELLATION AND NO SHOW POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and progress toward your goals is something everyone in our clinic takes quite seriously.

Because we care so much about you, we realize that it would be a disservice to you if we did not emphasize the importance of our won commitment to the care you need to receive and to the actions we ask you to do.

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep all your appointments. With the exception of serious emergencies, it is expected that you keep all your appointments. If you need to re-schedule an appointment, we request at least ***24 hour notice***. Your appointment time is very important to us. If we do not receive 24 hour notice of your cancellation, it limits our ability to accommodate other patients who may need that time slot. SCAR aims to provide the best possible care for our patients. Attending scheduled appointments is a necessary part of your treatment process. Adhering to our cancellation and no show policy is a courtesy to both our staff and other patients who are trying to arrange appointment times.

In an instance of cancellation without 24 hour notice, we reserve the right to charge you a $25 fee. In an instance of a no-show, you will be charged a $25 fee as well. Repeated cancellations and/or no shows demonstrate a lack of commitment to your healthcare. We understand issues come up that are beyond your control, therefore, late cancellation due to illness or family emergency is ***excluded*** from this policy.

_____ _____

Patient/Guardian Signature: Date

APPOINTMENT POLICY

Patients are seen at Sports Conditioning and Rehabilitation (SCAR) by appointment only. Scheduling is based on a first come, first serve basis. It is advisable for you to schedule your appointments in the entire treatment plan that your physical therapist has prescribed for you to ensure you get a time that works well in your day. It is your responsibility to ensure your appointments have been arranged with the front office. If you are unsure of your scheduled appointments, please feel free to check with the staff, and a reminder card will be provided to you.

Patient supervision during treatment is important to insuring safe and effective care. To adhere to this supervision policy, we request that upon your arrival you check in at the front desk prior to coming back for your scheduled appointment.

***Reminder:** Please notify your physical therapist of your next scheduled appointment with your referring physician. If you have already scheduled your next appointment please provide is below:

Next Physician Appointment Date: _____

If you have further questions regarding any of the above policies or your treatment in general, please do not hesitate to ask any of the Sports Conditioning and Rehabilitation staff.

_____

Patient/Guardian Signature:

_____ _____

Patient/Guardian Printed Name: Date

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SUMMARY OF NOTICE OF PRIVACY PRACTICES

A new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") goes into force on April 14, 2003. We are required to give you a printed copy of our Notice of Privacy Practices. For your convenience, we are providing this brief summary. Each section has a corresponding section in our full Notice, which we encourage you to read in its entirety. We are required to ask you to sign a one-time acknowledgment that you have received our full Notice.

YOUR RIGHTS AS A PATIENT. You have many new and important rights with respect to your protected health information. These are summarized below and described in detail in our full Notice of Privacy Practices.

USE OF PROTECTED HEALTH INFORMATION. We are permitted to use your protected health information for treatment purposes, to facilitate our being paid, and to conduct our business and evaluate the quality and efficiency of our processes. Also, we are permitted to disclose protected health information under specific circumstances to other entities. We have put into place safeguards to protect the privacy of your health information. However, there may be incidental disclosures of limited information, such as overhearing a conversation, that occur in the course of authorized communications, routine treatment, payment, or the operations of our practice. HIPAA recognizes that such disclosures may be extremely difficult to avoid entirely, and considers them as permissible. For entities that are not covered under HIPAA to which we must send protected health information for treatment, payment, or operational purposes, we require that they sign a contract in which they agree to protect the confidentiality of this information.

DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR AUTHORIZATION. For disclosures that are not related to treatment, payment, or operations, we will obtain your specific written consent, except as described below.

DISCLOSURES OF PROTECTED HEALTH INFORMATION NOT REQUIRING YOUR AUTHORIZATION. We are required by state and federal law to make disclosures of certain protected health information without obtaining your authorization. Examples include mandated reporting of conditions affecting public health, subpoenas, and other legal requests.

COMMUNICATION TO YOU OF CONFIDENTIAL INFORMATION BY ALTERNATIVE MEANS. If you make a written request, we will communicate confidential information to you by reasonable alternative means, or to an alternative address.

RESTRICTIONS TO USE AND DISCLOSURE. You may request restrictions to the use or disclosure of your protected health information, but we are not required by HIPAA to agree to such requests. However, if we do agree, then we are bound to honor your request. In the course of our use and disclosure of your protected health information, only the minimum amount of such information will be used to accomplish the intended goal.

ACCESS TO PROTECTED HEALTH INFORMATION. You may request access to or a copy of your medical records in writing. We will provide these within the time period specified, unless we are forbidden under HIPAA or by applicable state law to provide such records. If we deny access, we will tell you why. You may appeal this decision, which, under specified circumstances, will be reviewed by a third party not involved in the denial.

AMENDMENTS TO MEDICAL RECORDS. You may request in writing that corrections be made to your medical records. We will either accept the amendments, and notify appropriate parties, or deny your request with an explanation. You have rights to dispute such denials and have your objections noted in your medical record.

ACCOUNTING OF DISCLOSURES OF PROTECTED HEALTH INFORMATION. You may request in writing an accounting of disclosures of your protected health information. This accounting excludes disclosures made in the course of treatment, payment, or operations, and disclosures that were made as a result of your written authorization.

OTHER USES OF YOUR HEALTH INFORMATION. Optional uses, as permitted under HIPAA, are listed in our complete Notice of Privacy Practices.

HOW TO LODGE COMPLAINTS RELATED TO PERCEIVED VIOLATIONS OF YOUR PRIVACY RIGHTS. You may register a complaint about any of our privacy practices with our Privacy Official or with the Secretary of Health and Human Services without fear of retaliation, coercion, or intimidation. For a full copy please ask your physical therapist.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONFIDENTIALITY

Use and disclosure of protected health information is regulated by the federal law known as The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Under HIPAA, providers of healthcare are required to give patients their Notice of Privacy Practices for Protected Health Information and make good faith effort to obtain a written acknowledgement that this notice was received.

Therefore, I_____(Print Patient Name or Guardian) acknowledge that Sports Conditioning and Rehabilitation of CA, Inc, has provided a written copy of its Notice of Privacy Practices for Protected Health Information to myself/guardian.

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent

In the event that we need to contact you:

Which phone number would you prefer we call (please circle all that are acceptable)? Cell Home Work

May we leave a message on an answering machine or with someone at the acceptable numbers? Yes No

May we contact you by e-mail or by text? Yes No

Please provide the following physician information should we need to contact them to discuss your current or past condition

Referring Physician Name:_____ Phone: _____

Primary Care Physician Name:_____ Phone: _____

Other Physician Name:_____ Phone:_____

Is there anyone besides your physician you give us permission to talk to regarding your fitness or physical therapy care? Yes No

1. Name:_____Relationship:_____Phone Number: _____
2. Name:_____Relationship:_____Phone Number: _____

_____ _____

Patient/Guardian Signature Date

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