NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Stelly Physical and Occupational Therapy, LLC'S LEGAL DUTY

Stelly Physical and Occupational Therapy, LLC is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Stelly Physical and Occupational Therapy, LLC uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Stelly Physical and Occupational Therapy, LLC may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Stelly Physical and Occupational Therapy, LLC may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We also provide information when required by law.

In any other situations, Stelly Physical and Occupational Therapy, LLC 's policy is to obtain your written authorization before disclosing you personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Stelly Physical and Occupational Therapy, LLC may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

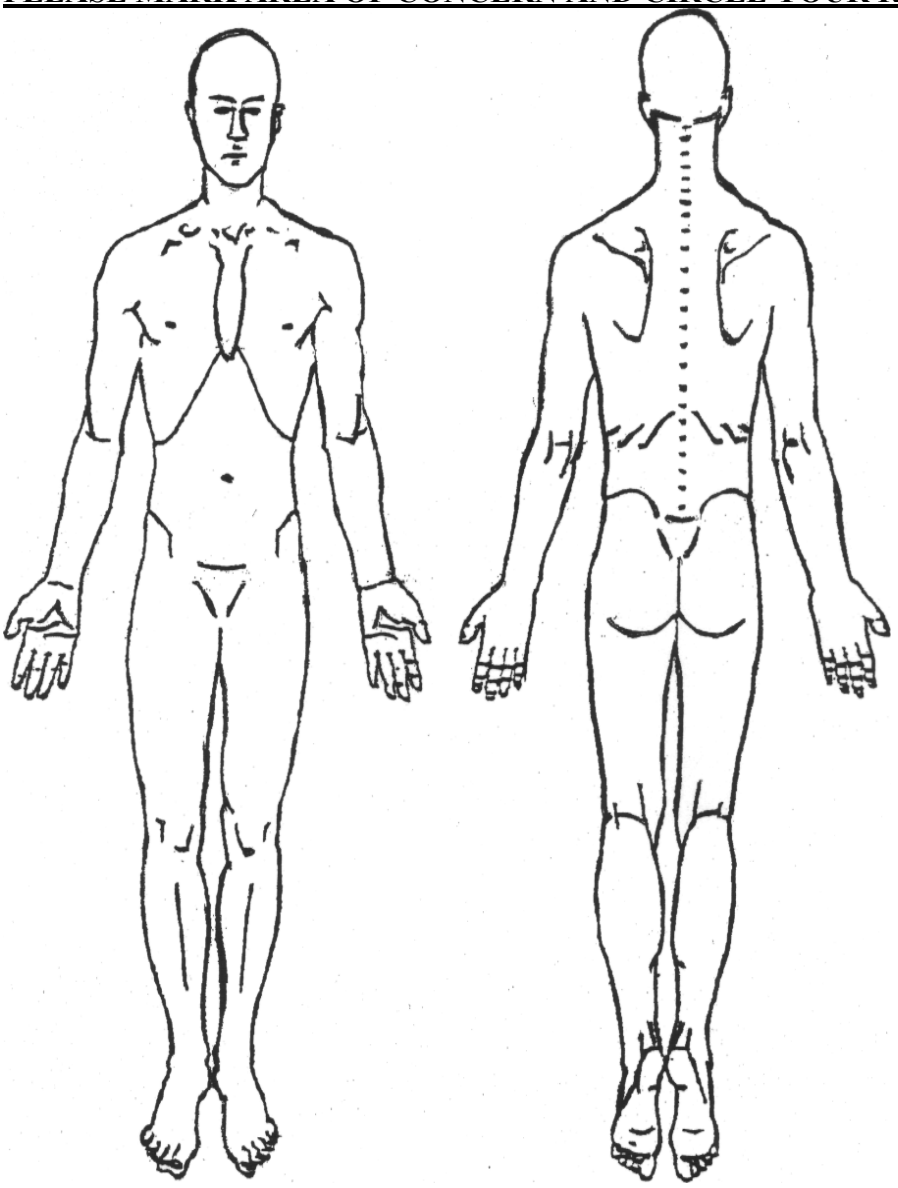
You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Stelly Physical and Occupational Therapy, LLC will consider all such requests on a case by cases basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Stelly Physical and Occupational Therapy, LLC may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed above. You may also send a written complaint to the US Department of Health and Human Services.

March 3, 2008

PLEASE MARK AREA OF CONCERN AND CIRCLE YOUR RATE OF PAIN AT ITWORST



Rate your pain on a scale of 1 – 10 with 10 being the greatest.
1 2 3 4 5 6 7 8 9 10

*Have you fallen within the past year? YES or NO

*If YES--- How many times have you fallen? 1 2 3 4 5 6 7 8 9 10

*If YES--- What were the causes of your fall or falls? _____

Doctor use only: Height: _____ Weight:_____Functional Score: _____ PHQ-9/GDS:_____

Stelly Physical and Occupational Therapy, LLC

Medications List

(Please **LIST** any medications you are currently taking)

Patient Name: **Date:**

Medications:	**Milligrams**:	**Daily Dosage**:

Patient Signature: _____

Stelly Physical and Occupational Therapy, LLC
Patient Medical History

Patient Name_____Date_____
Referring Physician: _____Next appointment: _____

*Check which is relative to you:
___work related injury ___motor vehicle accident ___recurrence of previous injury
___injury related to lifting ___Athletic/recreational injury ___cause unknown
___other:_____
*Date of Injury _____
*Have you ever had surgery related to this injury? ____YES ____NO
*Is this a litigation case? YES NO Attorney's name: _____
*Circle if recently had one done: MRI / X-Rays / CAT SCAN Where? _____

***CIRCLE-- YES OR NO** to the following medical conditions, past or present:

			On Set Date of Disorder:
Allergy to Aspirin	YES	NO	_____
Allergy--poor tolerance to Heat or Cold	YES	NO	_____
Allergy to Latex	YES	NO	_____
Asthma/Breathing problems	YES	NO	_____
Bowel/Bladder problems	YES	NO	_____
Cancer	YES	NO	_____
Chest pain/Angina	YES	NO	_____
Clinically Diagnosised **Dementia**	YES	NO	_____
Clinicaly Diagnosised **Depression**	YES	NO	_____
Diabetes	YES	NO	_____
Dizziness/Fainting	YES	NO	_____
Headache	YES	NO	_____
Heart Disease	YES	NO	_____
Heart Palpation	YES	NO	_____
Hernia	YES	NO	_____
High Blood Pressure	YES	NO	_____
Joint Replacements	YES	NO	_____
Kidney Problems	YES	NO	_____
Liver/Gallbladder problems	YES	NO	_____
Metal Implants	YES	NO	_____
Nausea/Vomiting	YES	NO	_____
Osteoporosis	YES	NO	_____
Pace maker	YES	NO	_____
Pregnant	YES	NO	_____
Recent fractures	YES	NO	_____
Rheumatoid Arthritis	YES	NO	_____
Ringing in ears	YES	NO	_____
Seizures	YES	NO	_____
Sexual Dysfunction	YES	NO	_____
Tobacco Use—**Smoking or Other**	YES	NO	_____
Stomach Ulcers	YES	NO	_____
Surgeries	YES	NO	_____
Tuberculosis (TB) Exposure	YES	NO	_____

Circle any that may apply:
Hepatitis C, HIV, STD: _____ YES___ NO___ _____

Signature _____ Relationship to Patient _____

Stelly Physical and Occupational Therapy, LLC

Patient Activity Form

Patient Name_____Date_____

Please check the appropriate column for each activity listed.

	NO DIFFICULTY	MINIMAL DIFFICULTY	MODERATE DIFFICULTY	MAXIMAL DIFFICULTY
1. Sitting	_____	_____	_____	_____
2. Standing	_____	_____	_____	_____
3. Driving	_____	_____	_____	_____
4. Getting in/out of car	_____	_____	_____	_____
5. Walking in the home	_____	_____	_____	_____
6. Walking in the neighborhood	_____	_____	_____	_____
7. Shopping	_____	_____	_____	_____
8. Using the stairs	_____	_____	_____	_____
9. Bathing	_____	_____	_____	_____
10. Getting dressed	_____	_____	_____	_____
11. Grooming	_____	_____	_____	_____
12. Preparing food/cooking	_____	_____	_____	_____
13. Rolling in bed	_____	_____	_____	_____
14. Lifting _____#	_____	_____	_____	_____
15. Carrying	_____	_____	_____	_____
16. Reaching	_____	_____	_____	_____
17. Putting on seat belt	_____	_____	_____	_____

STELLY PHYSICAL AND OCCUPATIONAL THERAPY, LLC
NEW PATIENT INFORMATION FORM

Patient Name: _____ Social Security #: _____

Date of Birth: _____ Age: _____ Sex: Male/Female

Email: _____

Address: _____City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact Person & Phone #: _____

Marital Status: (circle one) Married Divorced Single Widowed

*******Account & Billing Information*******

I agree to inform Stelly Physical and Occupational Therapy, LLC of any insurance changes as they may occur.

Policy Holder: _____ Policy Holder Employer: _____

Relationship to Patient (circle one): Spouse Parent/Guardian Other

Did you sustain this injury at work? YES NO

Is this currently a Workers Compensation case? YES NO

If NO, could this turn into a Workers Compensation Case? YES NO

W/C Claim No: _____ Company/Adjuster: _____

If yes, please explain: _____

Please provide our clinic with copy of Drivers license and all insurance cards.

*****APPOINTMENTS MUST BE MADE WEEKLY AT THE FRONT DESK*****

Payments to this clinic can be made with Cash, Check, Visa, Mastercard or Discover.

I acknowledge that the information I have provided is true and I am ultimately responsible for payment of all charges incurred for my therapy. If my insurance benefits/any settlements from litigation are not sufficient to pay for these services, then I personally guarantee payment. I authorize my insurance to make payment for services rendered to me /dependent directly to the provider. Any account remaining unpaid without satisfactory arrangements may be turned over to a collection agency. Should my account be referred to an agency for collection, I agree to pay reasonable collection fees on the unpaid balance. I hereby authorize Stelly Physical and Occupational Therapy, LLC to render treatment to me as ordered by my physician and grant permission to Stelly Physical and Occupational Therapy, LLC to obtain my medical compensation carrier/third party guarantor as needed to collect. WORKERS COMPENSATION - I hereby authorize my rehab consultant/nurse case manager/adjuster to receive my records related to my work injury.

Signature_____Date_____

MEDICARE PATIENTS ONLY - Are you receiving treatment with Home Health?
YES or NO

If yes: (List Home Health Company Name) _____

Stelly Physical & Occupational Therapy, L.L.C.
FINANCIAL AGREEMENT

Date: _____

Patient Name: _____

I, _____, understand that services rendered to me by Stelly Physical & Occupational Therapy, L.L.C. are my financial responsibility and that the Provider will bill my insurance company, (_____) as a courtesy. I authorize my insurance company to pay my benefits directly to Stelly Physical and Occupational Therapy, L.L.C. and I understand that I will be fully responsible for any outstanding balance on my account. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by my Insurance Company.

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to Stelly Physical and Occupational Therapy, L.L.C. within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the **collections process**; I will be responsible for any cost incurred by the office to retrieve their monies. In the event that I receive any check, draft, or other payment subject to this Agreement, I will immediately deliver said check, draft, or payment to Provider. Any violations of this agreement will, at Provider's election, terminate patient charge privileges with Provider and bring any balance owed by Patient to Provider immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize (Provider) to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Agreement shall be considered as effective and valid as the original.

I authorize the provider to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Dated: _____ Witness: _____

_____

Signature of Policyholder

_____

Patient /Guardian Printed Name

STELLY PHYSICAL AND OCCUPATIONAL THERAPY, LLC
PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Stelly Physical and Occupational Therapy, LLC Notice of Information Practices. I understand that Stelly Physical and Occupational Therapy, LLC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to my treatment/payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Stelly Physical and Occupational Therapy, LLC Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Please sign only the 1st line.

_____ _____

Patient's Signature **Date**

_____ _____

Patient's Signature **Date**

_____ _____

Patient's Signature **Date**

_____ _____

Patient's Signature **Date**

Stelly Physical & Occupational Therapy, LLC

Credit Card Payment Authorization

*****Optional*****

We understand that convenience is not often associated with today's healthcare environment. Our Practice not only focuses on excellent healthcare service but also how to provide service as cost and time effectively as possible. We have found that collecting all known liability at the time of service is not only beneficial for the practice, but experience has proven that our patients appreciate knowing they will not have to worry about delayed billing or payments.

We provide secured methods of accepting your payment at the time of treatment and also for keeping your credit card on file to handle any remaining balance after insurance company reimbursement.

We will work with you in establishing a payment schedule if necessary, using this credit card authorization form. No amount listed on this form may be less than $25.00 due to credit card fees SPOT incurs.

I _____, authorize Stelly Physical and Occupational Therapy, L.L.C.,

to keep my signature and credit card information on file and to charge my account for the balance remaining on the 10th day of every month not to exceed $_____ per month until balance is paid in full.

I understand the provider is offering this as a courtesy and I may pay my balance in full at any time and cancel this agreement. I am authorizing the use of this card for:

Patient Name: _____

Card Holder Name: _____

Card Holder Address: _____Zip: _____

Type of Credit Card: _____ CC #: _____

Expiration Date: _____ Security Code: _____

Email Address: _____

Signature: _____

Date: _____