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 your 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.

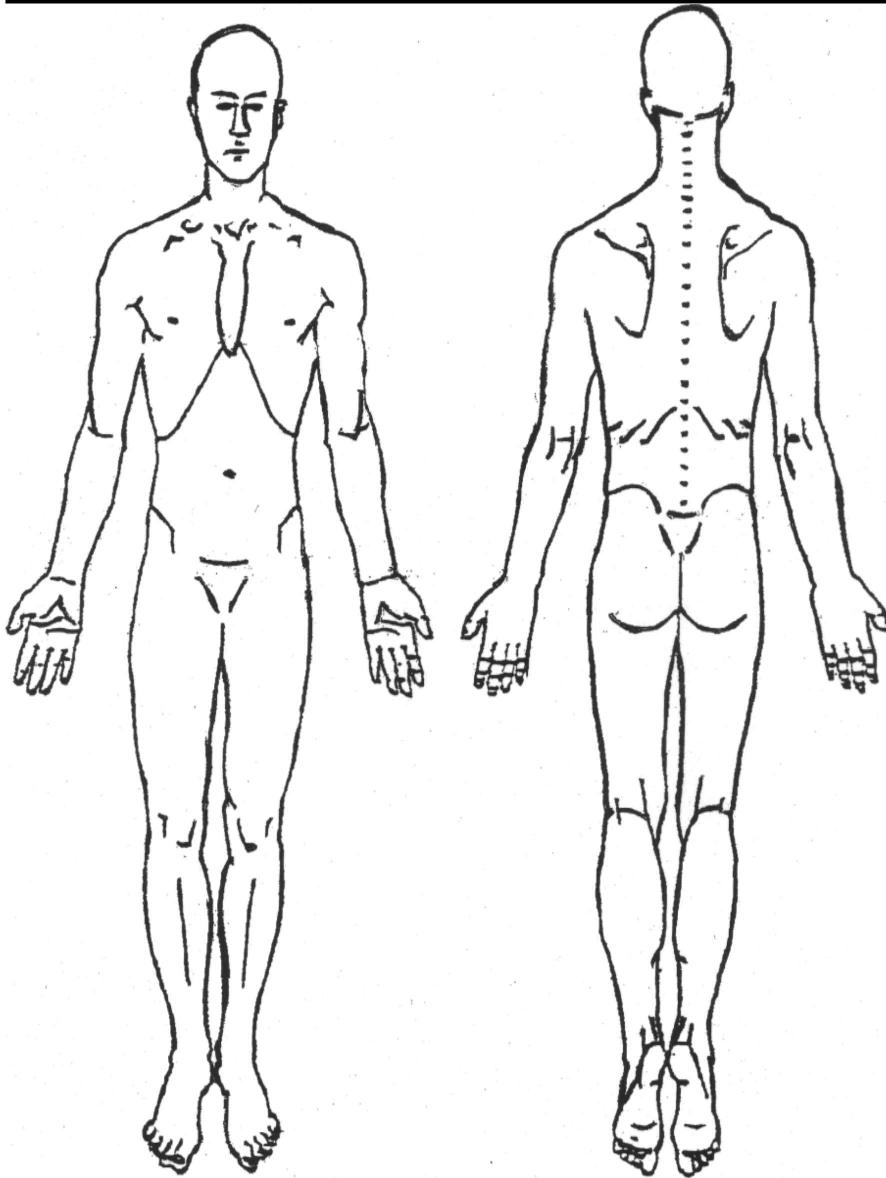
You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Stelly Physical and Occupational Therapy, LLC will consider 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.

February 2023

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**:

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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	_______________
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
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) ____

***Has the patient received physical therapy at another clinic in the year 2023?** YES or NO

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: ____________________________

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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.

Note: A 4% card processing convenience fee will apply to all payments made in office or through this form due to the percentage rates credit card companies are charging.

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: ____