PATIENT INFORMATION ACKNOWLEDGEMENT FORM

Please see our **NOTICE OF PATIENT INFORMATION PRACTICES** displayed in the lobby.

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.

ONLY sign the 1st line.

_____ _____

Patient Signature **Date**

_____ _____

Patient Signature **Date**

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

Stelly Physical and Occupational Therapy, LLC

Patient Name:_____ Sex: Male/Female

Date of Birth: _____ Age: _____ Social Security #: _____

Marital Status: (circle one): Married Divorced Single Widowed

Email: _____ Phone Number: _____

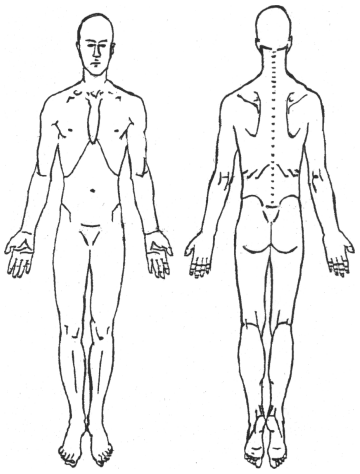
Mailing Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact Person & Phone #: _____

Referring Physician: _____
*Date of Injury _____
*How did this injury occur? _____
*Have you ever had surgery related to this injury? ____YES ____NO
*Circle Is this a Litigation or Workers Compensation case? YES NO
If **YES** Attorney's / Adjuster's name: _____
*Circle if recently had one done: MRI / X-Rays / CAT SCAN Where? _____

PLEASE MARK THE AREA OF CONCERN



Circle your rate of pain at its worst 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 and what were the causes of your fall(s)?_____

_____

Patient Signature: _____

Stelly Physical and Occupational Therapy, LLC

Medications List

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

Medications & Daily Dosage:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient Medical History

*__CIRCLE-- YES OR NO__ to the following medical conditions, past or present:

			On Set Date of Disorder:
Allergy--poor tolerance to Heat or Cold	YES	NO	_____
Allergy to Latex	YES	NO	_____
Asthma/Breathing problems	YES	NO	_____
Cancer	YES	NO	_____
Clinically Diagnosed **Dementia**	YES	NO	_____
Clinically Diagnosed **Depression**	YES	NO	_____
Diabetes	YES	NO	_____
Dizziness/Fainting	YES	NO	_____
Heart Disease	YES	NO	_____
High Blood Pressure	YES	NO	_____
Joint Replacements	YES	NO	_____
Metal Implants	YES	NO	_____
Osteoporosis	YES	NO	_____
Pace maker	YES	NO	_____
Pregnant	YES	NO	_____
Rheumatoid Arthritis	YES	NO	_____
Seizures	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 _____

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 2024? YES or NO**

Stelly Physical and Occupational Therapy, LLC

FINANCIAL AGREEMENT

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.

Signature: _____ Date: _____

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_____

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

Stelly Physical and 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: _____

Type of Credit Card: _____ CC #: _____

Expiration Date: _____ Security Code: _____

Signature: _____

Date: _____