Madison Performance Therapy Clinic
501 Baptist Drive, Suite 110
Madison, MS 39110
601.898.5777 – office

Thank you for choosing Madison Performance Therapy for your physical therapy care.

Please complete the attached forms and bring them with you when you arrive for your appointment.

If you need to reschedule or cancel your appointment, please call us at 601-898-5777 at least 24-hours in advance. You may leave a message on our voice mail if we are not available when you call. There is a $25 fee if you do not cancel or reschedule at least 24-hours prior to your scheduled appointment time. This fee is **not** covered by insurance.

Please arrive **15 minutes before** your appointment, if you have completed your paperwork. If you **DO NOT** have your paperwork completed, please arrive **30 minutes prior** to your appointment.

Please bring your **order for physical therapy from your doctor**, **picture ID** and **insurance cards** along with these **completed forms** with you to your first appointment.

If your insurance shows you have a co-pay, we will collect that each time you come for therapy. Once your insurance has responded to us letting us know what your patient responsibility is, we will collect any applicable deductibles and co-insurance at the time of your visits, so please come prepared to each visit.

Please be sure and bring a list of all medications that you are currently taking. If you have any MRI's or medical records that you feel may help your therapist in your treatment, please bring those as well for them to review.

If this visit is due to an accident that is covered by Worker's Compensation, please understand that your treatment must be pre-approved by your worker's comp carrier before we can treat you. We will not be able to schedule your appointment until you have been approved by your worker's comp carrier. Please let the front desk know that your injury is a worker's comp injury, and we will give you an information form so we can contact your worker's comp carrier to request approval. Once approved, we will call you to schedule your appointment.

We do not accept third-party insurance.

PLEASE DO NOT MAIL OR EMAIL THIS PAPERWORK, BRING IT WITH YOU TO YOUR APPOINTMENT.

Thank you!

Madison Performance Therapy Clinic

Please Print. Use your legal name, do not use nicknames. Complete all of application.

Patient Name: _____ Entitlement: _____
(Last) (First) (Middle) (Jr., Sr., III, etc.)

Social Security #_____ Sex_____ Marital Status _____ Date of Birth_____

Address_____ Apt #_____

City_____ State_____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer Name_____

Work Address_____ City/State/Zip_____

Occupation_____ Date of Retirement_____

Family Physician_____

GUARANTOR INFORMATION: If the patient is under 18, please indicate who is financially responsible for the payment of the account.

Name: _____ Entitlement:_____
(Last) (First) (Middle)

Social Security #_____ Sex_____ Marital Status _____ Date of Birth_____

Address_____ Apt #_____

City_____ State_____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer Name_____

Work Address_____ City/State/Zip_____

Occupation_____ Date of Retirement_____

EMERGENCY CONTACT INFORMATION: Person to contact in the case of an emergency. Spouse if married.

Name: _____ Relationship:_____
(Last) (First) (Middle)

Address_____ Apt #_____

City_____ State_____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

MADISON PERFORMANCE THERAPY CLINIC

INSURANCE INFORMATION

PLEASE PRINT CLEARLY

PRIMARY INSURANCE _____ GROUP #_____

MEMBER ID OR POLICY #_____

SUBSCRIBER'S NAME_____ _____ RELATIONSHIP_____

SUBSCRIBER'S SOCIAL SECURITY #_____ DATE OF BIRTH: _____

ADDRESS: _____ CITY:_____ STATE_____ ZIP_____

SECONDARY INSURANCE _____ GROUP #_____

MEMBER ID OR POLICY #_____

SUBSCRIBER'S NAME_____ _____ RELATIONSHIP_____

SUBSCRIBER'S SOCIAL SECURITY #_____ DATE OF BIRTH: _____

ADDRESS: _____ CITY:_____ STATE_____ ZIP_____

MADISON PERFORMANCE THERAPY CLINIC

CONSENT FOR TREATMENT

_____ initial **Authorization to Release:** I hereby authorize the Madison Performance Therapy Clinic to release or disclose to insurance companies and/or outpatient benefit programs information from my medical record, including demographic information not to exclude the social security number, pertaining to my treatment needed to process insurance claims and/or continuum of care.

_____ initial **Authorization to Pay Insurance Benefits:** I hereby assign payment directly to the Madison Performance Therapy Clinic benefits wherein specified and otherwise payable to me but not to exceed Madison Performance Therapy Clinic regular charges for medical treatment. I understand I am financially responsible for charges not covered by this authorization.

_____ initial **Consent For Treatment:** The undersigned authorizes the Madison Performance Therapy Clinic assigned to furnish medical treatment by those means he/she considers necessary and proper in the treatment of the patient identified below while a patient at Madison Performance Therapy Clinic.

_____ initial **Financial Agreement:** For services rendered to the patient named below, I the undersigned, agree to pay all professional, outpatient, hospital visit charges not covered by insurance and/or no show appointment fee. I also agree to pay reasonable attorney and/or collection fees necessary for the collection of payment.

_____ initial **Valuables:** The undersigned hereby releases the Madison Performance Therapy Clinic and/or its staff of employees from any responsibility due to loss or damage of any valuables that the patient may keep in his/her possession or that may be brought to him/her by other persons.

_____ initial **Fee for Release of Records:** I understand that there may be a charge for providing me or my representative(s) copies of my medical records in accordance with the guidelines provided by the MS State Board of Medical Licensure.

_____ initial **Insurance Verification:** I understand that it is my responsibility to check with my insurance company(s) to verify that Madison Performance Therapy Clinic and its therapists are in my insurance network.

_____ initial **Patient Acknowledges Receipt of Privacy Practices:** Our **Notice of Privacy Practices and Your Rights Regarding Your Information** provides information about how we may use and disclose protected health information about you. You have the right to review our **Notice of Privacy Practices** before signing this acknowledgement. A copy of our **Notice of Privacy Practices** is provided in our admission paperwork. By initialing this statement, you agree that you have received and reviewed our **Notice of Privacy Practices** and have no further questions regarding this form.

_____ initial **Term:** The term of this **Consent for Treatment** shall be good for a period of one year from the date of this signature below, unless otherwise revoked.

Patient or Responsible Party Signature_____ Date_____

Printed Name _____

MADISON PERFORMANCE THERAPY CLINIC

ACCIDENT INFORMATION

Please Print Clearly

Is your injury related to an accident? YES NO (If no, skip remainder of questions and sign and date below)

If this is an accident, when did it occur? Date _____ Time _____

Where did your accident happen? _____

Please describe your accident_____

_____

Are you pursuing a liability claim against a third-party? YES NO

If the accident was related to a fall, please complete the following:

Name of Business or Person Owning the Property_____

Address_____

City/State/Zip_____

Is this a Worker's Comp claim? YES NO (If yes, please complete the following)

Date of Injury _____ Claim #_____

Employer_____

Address_____

City/State/Zip_____

HR Contact Person _____ Phone_____

Worker's Comp Insurance Carrier _____

Case Manager or Adjuster's Name_____ Phone_____

PRINT NAME _____

SIGNATURE _____ DATE_____

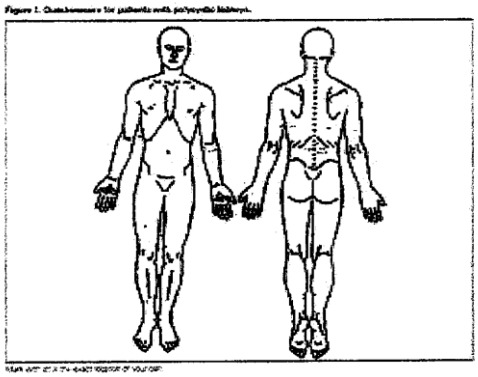
MADISON PERFORMANCE THERAPY CLINIC

MEDICAL HISTORY

Name: _____ **Age:** _____

Your Major Concern: _____

Mark with an X the location of your pain.



Please rate your pain on a 0-10 scale. 0 indicates pain-free; 10 indicates worst pain imaginable.

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0 1 2 3 4 5 6 7 8 9 10

What makes your pain better? _____

_____

What makes your pain worse?

_____

Are you presently working? YES NO

What is your occupation? _____

Do you drink alcohol? YES NO If yes, how many days a week do you consume alcohol? _____

Do you smoke? YES NO If yes, how many packs of cigarettes per day? _____

Have you ever been diagnosed with any of the following conditions?

1. **High Blood Pressure** YES NO
2. **Diabetes** YES NO
3. **Heart Problems** YES NO
4. **Seizures** YES NO
5. **Asthma** YES NO
6. **Cancer** YES NO
   Type of Cancer_____
7. **HIV/AIDS** YES NO

MADISON PERFORMANCE THERAPY CLINIC

MEDICAL HISTORY

Are there any other medical conditions that will affect your treatment? _____

_____

_____

Are you currently receiving home health? _____

Have you for any reason had any outpatient physical therapy visits this calendar year? YES NO

If yes, approximately how many visits? _____

Please circle any of the following whose care you are currently under:

Physical Therapist Chiropractor Medical Doctor/Osteopath

Other: _____

Please list any prescription medications you are taking (pills, injection, patches):

_____

_____

Do you have any known medication allergies? YES NO

Please list: _____

Are you allergic to Latex? YES NO

Please list any surgeries with approximate dates:

_____

_____

Please indicate any of the following symptoms you have recently noted:

Weight loss / gain Fever / chills / sweats Fatigue Weakness

Dizziness Night pain Nausea / vomiting Numbness / Tingling

Please indicate your goals for physical therapy: _____

_____

Is there anything else you would like your therapist to know? _____

_____

MADISON PERFORMANCE THERAPY CLINIC

STUDENT DEMOGRAPHIC PAGE

Please Print Clearly. Complete all sections.

Name: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____

Contact Phone #: _____

School: _____ Grade: _____

Is this injury related to school sports? YES NO If so, what sport? _____

If school related, has your school been notified of this injury? YES NO

Is this injury related to a recreational league sport? YES NO If so, what sport? _____

***Many times, schools and/or recreational leagues carry insurance that will serve as secondary to your personal insurance policy. Please let us know if you have one of these supplemental policies.**

Parent Name: _____

Contact Phone #: _____

Who referred you to our clinic? _____

Effective Date of Notice: 4-1-2014

NOTICE OF PRIVACY PRACTICES

Madison Performance Therapy Clinic
501 Baptist Drive, Suite 110
Madison, MS 39110
601-898-5777

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, THIS IS FEDERAL LAW MANDATED.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment, ordering test, referring you to another physician, or getting copies of your health information from another professional you have seen before. Examples of how we use or disclose your health information for payment purposes are: asking you about your health care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws.
- disclosure for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime, to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death, or to funeral directions to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;
- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the President or high ranking government officials; for lawful national intelligence activities; for military purpose; or for the evaluation and health of members of the foreign service;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form" as determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours. If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

- ask to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E-mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E-mail to your personal E-mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office address or fax shown at the beginning of this Notice.
- ask to see or get copies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E-mail shown at the beginning of the Notice.
- ask us to amend your health information if you that that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office at the address or fax shown at the beginning of this Notice.
- Get a list of the disclosures that we have made of your health information within the past six years (or shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office at the address or fax shown at the beginning of this Notice.
- Get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office at the address or fax shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office at the address or fax shown at the beginning of Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office at the address or phone number shown at the beginning of this Notice.