

## **Notice of Patient Information Practices**

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

Imagine Physical 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**

Imagine Physical 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, Imagine Physical Therapy, LLC may use your protected 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.

Imagine Physical 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 situation, Imagine Physical 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 disclosure at any time.

Imagine Physical Therapy, LLC may change its policy at any time. When changes are made, a new Notice of Patient Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Patient 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. Imagine Physical Therapy, LLC will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

### **CONCERNS AND COMPLAINTS**

If you are concerned that Imagine Physical Therapy, LLC may have violated your privacy rights or if you disagree with any decision we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Imagine Physical Therapy, LLC's health information practices or if you have a complaint, please contact John Mart, owner of Imagine Physical Therapy, LLC.

Mount Pleasant  
3301 Stockdale Street  
Mt Pleasant, SC 29466  
843-375-5448

Daniel Island  
295 Seven Farms Dr, Ste 200B  
Daniel Island, SC 29492  
843-377-8820

West Ashley  
1964 Ashley River Rd, Ste C-1  
Charleston, SC 29407  
843-576-4121



...immeasurably more than you could ask or imagine.

Date: \_\_\_\_\_

Name (Last name, First name, "Nickname"): \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone - Home: \_\_\_\_\_

Cell: \_\_\_\_\_

Email Address: \_\_\_\_\_

Can we leave a detailed message on phone?  Yes  No On email?  Yes  No

Date of Birth: \_\_\_\_\_

Marital Status:  Married  Single  Widowed  Divorced  Separated

---

### **Insurance Information**

#### **Primary Insurance**

Insurance Carrier: \_\_\_\_\_

Policy ID: \_\_\_\_\_

#### **Secondary Insurance**

Insurance Carrier: \_\_\_\_\_

Policy ID: \_\_\_\_\_

*Complete this section if your insurance is in another individual's name.*

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Relationship to Insured: \_\_\_\_\_

---

### **Accident Details**

Employment Related:  Yes  No Accident Related:  Auto  Other

Date of Accident: \_\_\_\_\_

Details of Accident: \_\_\_\_\_

I authorize the release of any medical or other information necessary to process insurance claims. I also authorize the payment of medical benefits directly to Imagine Physical Therapy in West Ashley, LLC for the services rendered.

---

Signature

Date

**Imagine Physical Therapy, LLC Financial Policy**

**PAYMENT IS EXPECTED AT THE TIME SERVICES ARE RENDERED.  
ANY OTHER ARRANGEMENTS MUST BE MADE PRIOR TO TREATMENT.**

1. **COMMERCIAL/GROUP INSURANCE:** (BlueCross, Aetna, Cigna, etc): After verification of coverage with your insurance company/companies, we will file a claim as a courtesy to you. We reserve the right to release information for insurance purposes. If your deductible has not been met or cannot be verified, **WE WILL REQUIRE THE PAYMENT OF YOUR DEDUCTIBLE AMOUNT.** We then require that you pay the percentage/copay due by you, at the completion of each visit. We will allow 45 days for your insurance company to pay assigned claims, after which time we will hold you, the patient, responsible for payment of your account.
2. **WORKERS' COMPENSATION:** We will verify your workers' compensation coverage with your employer or the company where you were employed at the time of your accident. After verification, we will file your claims for you. If your Workers' compensation is denied for any reason, YOU will be responsible for your bill. If we have to file your group insurance (because your Workers' Compensation was denied), any amount not paid by your group insurance will be YOUR responsibility. (Please give us your group health insurance so we can have a copy on file should your workers' compensation be denied) Missed appointments will be reported to your employer, case manager, physician, and documented in your clinical record. Missed appointments may lead to the disruption of your workers' compensation payments if you do not follow the directives of your physician for treatment.
3. **MEDICARE: ALERT:** Coverage by Medicare will be limited for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services received on January 1, 2011 through December 31, 2011. The limits are \$1870 for PT and SLP combined and \$1870 for OT. Medicare pays up to 80% of the limits after the deductible (\$162) has been met. These limits do not apply to certain therapy approved by Medicare or to therapy you receive from hospital outpatient departments, unless you are a resident of and occupy a Medicare-certified bed in a skilled nursing facility. If you have any questions, please call 1-800-MEDICARE. You are responsible for the annual \$162 deductible. Medicare will only pay for physical therapy after expenses exceed \$162. Medicare will then pay 80% of the allowable charges. Therefore, YOU are responsible for the remaining 20%. If you have secondary insurance coverage and provide us with that information, we will bill your secondary insurance as a courtesy to you. If you do not have secondary insurance or your secondary insurance fails to pay for your services, YOU are responsible for the payment of the 20%. If Medicare denies charges because you have other insurance that is considered primary insurance, you will be responsible for all incurred charges. Please inform us of any other insurance coverage that you may have.
4. **AUTO ACCIDENT/ATTORNEY:** If you have been involved in an accident and have an attorney representing you, we prefer to bill your health insurance, to comply with the "timely submission of claims" provision of your policy. This will protect you in the event that your case is lost. However, if you decide to work solely through your attorney or liability insurance, you will be required to sign our Assignment of Benefits form. After signing this form, you waive your option for us to bill your primary insurance at a later date. If settlement is not reached with twelve (12) months of today's date, you will be billed for the balance in full.
5. **NO INSURANCE:** If you do not have insurance coverage, the charges incurred will be your responsibility. We are **MOST** concerned with your complete recovery. We are glad to work out a payment plan to insure that you get the maximum benefit from physical therapy.
6. **CANCELLATION/NO SHOW POLICY:** In order to receive the maximum benefit from you physical therapy, it is important to keep your scheduled appointments. We have dedicated an appointment time and paid staff members to be here for your scheduled appointment. Therefore, if you fail to attend your scheduled appointment, or do not call to cancel or reschedule your appointment within 24 hours of your scheduled appointment time, **you will be charged a \$30.00 no-show fee.** If you cancel or fail to show for three (3) consecutive appointments, you may be discharged from therapy.

*\*\*Please initial here acknowledging your awareness of the above cancellation policy.* \_\_\_\_\_

*\*\*Please provide the best method for us to contact you for appointment reminders.*

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

I have read the above policy and fully understand my responsibilities.

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

## PATIENT AUTHORIZATION AND CONSENT

Patient Name: \_\_\_\_\_

I hereby consent to treatment.

I authorize Imagine Physical Therapy, LLC and/or its subsidiaries and affiliates to obtain medical records and/or professional information from my physician or other medical professionals as it relates to my treatment.

I have received Imagine Physical Therapy, LLCs Notice of Information Practices. I understand that Imagine Physical Therapy, LLC and its subsidiaries and affiliates may use or disclose my personal health information to my insurance company, rehab nurse, case manager, attorney, employer, school, relate healthcare provider, assignees and/or beneficiaries and all other relates persons as it relates to my treatment. I understand that I have the right to restrict how my personal health information is used and disclosed if I notify the practice in writing. I also understand that Imagine Physical Therapy, LLC will consider requests on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby authorize one or all of the designated parties below to request the release of and receive any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Name & Relationship \_\_\_\_\_

Name & Relationship \_\_\_\_\_

Name & Relationship \_\_\_\_\_

Name & Relationship \_\_\_\_\_

From time to time Imagine Physical Therapy, LLC may want to use protected health information, comments, and/or photographs in target marketing campaigns, fund raising, and research studies.

I authorize Imagine Physical Therapy, LLC to use my protected health information, comments, and/or photographs as listed above.

I do not authorize Imagine Physical Therapy, LLC to use my protected health information, comments, and/or photographs as listed above.

**Payment Guarantee:** I agree to pay Imagine Physical Therapy, LLC, its subsidiaries and/or affiliates for the services provided to me or the party named above. If any law, such as Workers' Compensation, or insurance contract prohibits payment for these services, I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Imagine Physical Therapy, LLC and/or its affiliates or subsidiaries.

---

Patient/Guardian Signature and Date

**BRIEF MEDICAL HISTORY**

Patient Name: \_\_\_\_\_

Reason for Therapy: \_\_\_\_\_

Name of Referring Doctor: \_\_\_\_\_

How did injury occur? \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Have you received therapy for this injury?  Yes  No If yes, when? \_\_\_\_\_

Type of treatment. Was it successful? \_\_\_\_\_

Have you received Home Healthcare Services within the past 30 days?  Yes  No

What aggravates your symptoms? \_\_\_\_\_

What relieves your symptoms? \_\_\_\_\_

Please rate your pain between 0 and 10 (0 is no pain, 10 is likened to child birth or passing a kidney stone) \_\_\_\_\_

Do you now, or have you in the past, had any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Current Infections	<input type="checkbox"/>	<input type="checkbox"/>	Previous Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Heat/Cold Hypersensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Presently Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker Implant	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Controlled Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Metal in Body	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Previous Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Open Wounds	<input type="checkbox"/>	<input type="checkbox"/>	CVA/Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to any of the above, please explain and give approximate dates:

\_\_\_\_\_

Please list all current medications (prescriptions, over-the-counter, herbals, vitamins/minerals/dietary/nutritional supplements) and specify dosage:

\_\_\_\_\_

The information above is correct to the best of my knowledge. If anything changes, I agree to notify Imagine Physical Therapy, LLC and update this form.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date