Welcome to TherapySouth

Insurance Information

As a courtesy to you, we will bill your insurance company. Please provide us with your insurance card and any additional information we may need. We recommend that you call your insurance company to verify your physical therapy coverage if there is any discrepancy between what our office has been informed of and what you thought your benefit coverage was. It is your responsibility to know your policy benefits and limitations. Our billing office is available to answer questions you may have regarding our billing procedures.

Payment Options

We accept personal checks, cash, all major credit cards, and CareCredit. Insurance co-payments are due on each visit. Any portion of your treatments that are not covered by your insurance becomes your responsibility, and is due within 30 days. Interest may be charged at a rate of 1.5% per month (18% annually) for unpaid balances over thirty days old.

Return Check Fee

A $35.00 fee will be charged to the patient for each incident that a check is returned to us for insufficient funds.

Collection of Accounts

A $35.00 fee will be charged to the patient for any account turned over to collections for non- payment. Payment on account is due in full within 30 days from date of service.

Workers Compensation Claims

We will bill your open, approved workers' compensation claim. Please be advised that in the event your claim is denied, you are financially responsible for all charges.

Scheduling

We are happy to reschedule your appointments when a conflict occurs; however, we request a 24-hour notice if at all possible. If you fail to attend your appointments and do not give us 24 hour prior notification, you may be charged a fee of $50.00 for the time slot allotted for you.

Non-Discrimination

Admission to our clinic is non-discriminatory for services rendered, regardless of race, color, national origin, disability, or age. All clients who come to our clinic for services are protected against discrimination assured by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

Thank you for allowing us the opportunity to serve you. If you have any questions about the above information or any uncertainty regarding your insurance coverage, please do not hesitate to ask for our assistance.

_____

Patient Name (please print)

_____ _____

Patient/Legal Guardian Signature Date

Current Symptoms

Patient Name			Today's Date			Date of Birth
Gender ◯ Male ◯ Female	Age	Smoker ◯ Yes ◯ No	Pregnant ◯ Yes ◯ No	Height	Weight	Occupation
Primary Care Physician			May we send your doctor your physical therapy evaluation? ◯ Yes ◯ No			

What is your personal goal for therapy? Tell us more about how we can help you.

Where are you currently having symptoms?

How did it start? ◯ Gradually ◯ Suddenly ◯ Injury

What date (approximately) did your present pain start?	If injury, what was the injury date?

Where did injury occur? ◯ Home ◯ Work ◯ Automobile ◯ Sports

Are your symptoms currently: ◯ Getting better ◯ About the same ◯ Constant ◯ Intermittent

What is your CURRENT pain level, on a scale of 1-10?

What has been your WORST pain level, on a scale of 1-10?

Have you ever had this problem before? ◯ Yes ◯ No

If yes, how was the problem treated?

How long did it take for you to feel better?

What is your current activity level? ◯ Sedentary ◯ Active ◯ Regular Exercise Routine

How well do you sleep at night? ◯ Well ◯ With moderate difficulty ◯ Only with medication ◯ Unable to sleep due to pain

Please check each condition you are currently experiencing:

◯ Stiffness	◯ Difficulty sleeping	◯ Numbness or tingling	◯ Depression
◯ Tightness	◯ Constant pain	◯ Increased stress	◯ Changes in bowel/bladder
◯ Dizziness	◯ Intermittent pain	◯ Difficulty walking	◯ Increased pain at night
◯ Poor balance (falls)	◯ Headaches	◯ Pelvic pain	◯ Decreased mobility

Past Medical History

Please check each condition you have been told you have/had:

◯ Cancer	◯ Diabetes	◯ Kidney Disease	◯ Liver Disease	◯ Stroke
◯ High Blood Pressure	◯ Heart Disease	◯ Angina/Chest Pain	◯ Fibromyalgia	◯ Ulcers
◯ Osteoporosis/penia	◯ Osteoarthritis	◯ Rheumatoid Arthritis	◯ Incontinence	
◯ Unexplained weight loss	◯ Fever/chills/sweats	◯ Changes in appetite	◯ Nausea/vomiting	
◯ Allergies/Asthma	◯ Shortness of breath	◯ Difficulty swallowing	◯ Lung Disease	

Do you have any other conditions? ◯ Yes ◯ No If yes, please explain:

Have you had an MRI or other imaging? ◯ Yes ◯ No If yes, please describe results:

Have you had surgery(ies)? ◯ Yes ◯ No If yes, please list surgeries and approximate dates:

Have you had a recent illness? ◯ Yes ◯ No If yes, please explain:

Do you take blood thinners? ◯ Yes ◯ No

Are you allergic to latex? ◯ Yes ◯ No

Have you had 2 or more falls in the last 12 months? ◯ Yes ◯ No

Have you had any fall with injury in the last 12 months? ◯ Yes ◯ No

TherapySOUTH

Patient Information

Last Name	First Name	MI	Date of Birth

Social Security Number	Gender ◯ Male ◯ Female	Marital Status ◯ Single ◯ Married ◯ Other

Home Address	City	State	ZIP

Home Phone	Cell Phone	Email Address

Employment Status ◯ Full Time ◯ Part Time ◯ Student ◯ N/A	Employer/School Name	Title/Position

Work Address	City	State	ZIP

Work Phone	Have you been treated at any TherapySouth Clinic before? ◯ No ◯ Yes If yes, where?

How did you hear about TherapySouth?
◯ Physician ◯ Friend/Family ◯ Radio ◯ Print ad ◯ Internet ad ◯ Social Media ad ◯ Search Engine

Emergency Contact/Legal Guardian Information

Last Name	First Name	MI	Relationship to patient

Home Address	City	State	ZIP

Home Phone	Cell Phone	Email Address

Primary Insurance Company Information

Primary Insurance Name	Secondary Insurance Name	

Policyholder Name (if other than patient)	Gender ◯ Male ◯ Female	Date of Birth (of policyholder)

Social Security Number (of policyholder)	Phone Number (of policyholder)	Policyholder's relationship to patient

Injury-Related Information

Attorney Name		Attorney Phone Number	

Attorney Address	City	State	ZIP

Auto Liability Company Name	Contact Name	Phone Number	

Auto Liability Company Address	City	State	ZIP

Auto Liability Claim Number

Assignment of Benefits / Authorization of Release of Medical Information / Consent to Treatment

As the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility. I hereby assign all medical benefits to which I am entitled to TherapySouth in the event they file insurance on my behalf. I understand that I am Financially Responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment. I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection agency service fees, Attorneys fee, and all court costs and additional legal fees associated with the recovery of this debt.
I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of TherapySouth as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment except acts of negligence.

_____

Patient Name (please print)

_____ _____

Authorized Signature Today's Date

Patient Information Consent Form

I have read and fully understand the TherapySouth Notice of Patient Information Practices. I understand that TherapySouth 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 treatment of 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 company in writing. I also understand that TherapySouth will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in the TherapySouth Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the company in writing at any time.

Admission to our clinic is non-discriminatory for services rendered, regardless of race, color, national origin disability or age. All clients who come to our clinic for services are protected against discrimination assured by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

Thank you for allowing us the opportunity to serve you. If you have any questions about the above information of any uncertainty regarding your insurance coverage, please do not hesitate to ask for our assistance.

Designated Individuals Authorization

I hereby authorize one or all of the designated parties listed below to request and receive the release of 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
_____	_____
Patient Name	Primary Care Physician
_____	_____
Patient Signature	Today's Date

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 carefully.

TherapySouth Legal Duty

TherapySouth 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 disclosed herein.

Uses and Disclosures of Health Information

TherapySouth 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, TherapySouth 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.

TherapySouth may also use or disclose your personal health information without prior authorizations for public health purposes, for auditing purposes, and for emergencies. We may provide de-identified information for research studies. We also provide information when required by law.

In any other situation, TherapySouth 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.

TherapySouth may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of our clinic. 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 you personal health information for reasons other than treatment, payment, or other 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. TherapySouth will consider all such requests on a case-by-case basis, but the company is not legally required to accept them.

Concerns And Complaints

If you are concerned that TherapySouth may have violated your privacy rights or if you disagree with any decisions made of regarding access or disclosure of your personal health information, please contact our HIPAA Compliance Office 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 TherapySouth health information practices, or if you have a complaint, please contact the following office:

HIPAA Compliance Office
TherapySouth
2823 Greystone Comm Blvd.
Birmingham, AL 35242
phone (205) 745-3650 | fax (205) 745-3649