Grelot Physical Therapy

PATIENT INFORMATION

Name:____________________________________ DOB: ____/____/____ Social Security #: _____-___-______

Address: __________________________________City: ____________________ State: _____ Zip: ___________

Cell Phone: __________________ Home Phone: __________________ Work/ALT Phone: __________________

Marital Status: M S D W O Patient's Sex: ____ E-mail: ____

Emergency Contact: _____________________________ Relationship: ____________ Phone: ________________

DIAGNOSIS/COMPLAINT INFORMATION

Referring Doctor: _______________________ Diagnosis: ____

Injury caused by: ____Auto ____ Work ____ Other: ____

Date symptoms began: _______________ (If unknown, please be approximate)

INSURANCE INFORMATION

___Private Insurance ___Medicare ___HMO ___WC ___Private Pay ___Other: ____________

Name of Insurance company(s): ____

Policy/ID#: _________________________ Group #: ______________________ Effective: _________________

NAME OF INSURED/POLICY HOLDER

Name: ______________________________ Relationship to Patient: _______________________________

Social Security #: _____________________ DOB: ____________________ Phone: ________________

Address: _____________________________ City: _____________________ State: ____ Zip: _______

CONSENT FOR TREATMENT AND FINANCIAL RESPONSIBILITY

I hereby consent to have Grelot Physical Therapy provide the treatment and care prescribed by my physician or dentist. I understand this consent may be revoked by me at any time. I also hereby give lifetime authorization for payment or insurance benefits to be made directly to Grelot Physical Therapy for services rendered. I understand that I am financially responsible for all charges not paid for by my insurance company. ***I understand that I will be charged $25 for each missed visit which has not been cancelled within 24 hours of my scheduled appointment time.*** I will personally be responsible for this charge, as insurance companies do not reimburse for fees due to lack of compliance. I agree that if our balance becomes delinquent, defined as 90 days past due, and is referred to a collection agency or attorney, I shall be responsible for collection fees equal to 33&1/3% of the balance due in addition to the balance. I further understand and agree that if legal action is taken to collect the balance, I shall also be responsible for any court costs. I wave my rights under the laws and constitution of Alabama or any other state, to exempt my real personal property from execution.

I hereby authorize Grelot Physical Therapy to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement is as valid as the original. I also authorize that my signature on this form constitutes assignment of benefits to Grelot Physical Therapy.

____ ____________________________

PATIENT'S SIGNATURE DATE

GRELOT PHYSICAL THERAPY

5901 Grelot Rd.
Bldg B, Suite B
Mobile, AL 36609
Phone: (251) 343-1178
Fax: (251) 343-1741

Welcome to Grelot Physical Therapy. Your physician or dentist has referred you to physical therapy with a given diagnosis. Based on this referral, our therapist will perform an evaluation, develop a treatment plan, and treat your disease or injury or condition. We continually re-evaluate your progress and regularly report your progress to your physician or dentist.

Treatments are by appointment only. It is important to be prompt and keep your scheduled appointments. In consideration for us and other patients requiring care, *we ask that you give us 24- hours notice for any appointment cancellation*. We have voicemail for your convenience during non- working hours, weekends and holidays. **There is a $25 cancellation fee for each missed appointment.** You will personally be responsible for this charge as insurance companies do not reimburse for fees due to lack of compliance. Failure to give 24 hours notice, multiple cancellations, and rescheduling of appointments could result in discharge from our facility.

If you have health insurance, we will bill your insurance company for the services rendered. In order to provide this service, you will need to provide us with any and all information necessary to effectuate the billing process. *Please be advised that you are ultimately responsible for physical therapy services, medication, and patient billable supplies which are not covered by your insurance company.*

Our primary goal is to provide you with the highest quality physical therapy care and treatment possible along with assisting you to a speedy recovery. Please help us to assist you in your recovery by keeping all of your scheduled physical therapy appointments and performing your home programs as directed.

All copayments, coinsurances, deductibles and non-covered charges for physical therapy services will be collected at the end of each visit. We accept payment in the form of cash, checks, MasterCard, Visa and Care Credit. Any accounts that remain delinquent, defined as 90 days past due and are referred to a collection agency or attorney, you will be responsible for a collection fee equal to 33 1/3% of the balance due in addition to your balance.

In the event your account is placed with a collection agency or an attorney to recover the amount you are responsible for, all fees and costs associated with the collection process will be your responsibility. This includes any and all attorney fees and agency collection fees charged by any outside company to collect your debt.

Your signature below indicates that you understand and agree to our office and payment policies. Your signature also confirms that you will comply with your obligations listed above.

______________________________ ______________________

Patient's Signature **Date**

GRELOT PHYSICAL THERAPY

5901 Grelot Rd.
Bldg B, Suite B
Mobile, AL 36609
Phone: (251) 343-1178
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Acknowledgement of Receipt of **Notice of Privacy Practices**

Grelot Physical Therapy reserves the right to modify the privacy practices outlined in the notice.

Signature
I have received a copy of the Notice of Privacy Practices for Grelot Physical Therapy.

____
Name of Patient (Print or Type)

____
Signature of Patient

____
Date

____
Signature of Patient Representative
(Required if the patient is a minor or an Adult who is unable to sign this form)

____
Relationship of Patient Representative

NOTICE TO MEDICARE PATIENTS

As of January 1, 2019, Medicare has enforced a policy which caps any type of therapy benefits at a combined $2,080.00 per year. This means that if the charges for your outpatient therapy visits exceed $2,080.00 for the year, Medicare will not cover those services. Even if your doctor has deemed it medically necessary.

Please inform Grelot Physical Therapy if you have had any therapy visits (Physical Speech, Occupational Therapy, Home Health Care, Inpatient Facility Care, etc.) since January of this year. It is important that we know this information so that you, as a patient, do not have to pay for services over what Medicare will allow you.

Please sign this form, acknowledging that you understand this Medicare policy. If you have any questions, please do not hesitate to ask.

Thank you for your cooperation and for choosing Grelot Physical Therapy for your physical therapy needs!

____ I am **not** currently in an inpatient facility receiving treatment for this or other issues
Initial

____ I am **not** currently being visited by a Home Health Agency.
Initial

I understand the enforcements Medicare has put into place regarding Therapy Services.

________________________________ ________________________

Patient's Signature **Date**

GRELOT PHYSICAL THERAPY MEDICAL HISTORY FORM

Name:___________________________________Age:___________Occupation: ___________________

Currently Working? Yes / No________hours/week Student? Yes / No: Where:______________________

What brings you to physical therapy?____

What do you hope to achieve by coming to physical therapy?_____________________________________

Date of onset/injury: _________________Date of surgery: _________________

Have you had treatment from a medical practitioner? ______Describe:___________________________

Did that treatment help? ______Explain:____

Next appointment with practitioner who referred you to physical therapy? ______________

What tests have you had for this problem? __X-ray __Bone __Scan __ MRI __ EMG __ CT Scan ____

Where were tests done? ____

What were the results? ____

Are you currently receiving any other medical/health services? ____________________________________

Since it started, the pain is: getting worse improving the same

Describe the pain: sharp dull aching burning throbbing shooting cramping stabbing
__sore other ____

Check any activities you have difficulty with due to the problem for which you are seeking treatment:

☐ sleeping	☐ rising from a chair	☐ bathing	☐ getting in/out of bed
☐ dressing	☐ driving	☐ using	☐ light housekeeping
☐ standing	☐ self-care	☐ sitting	☐ getting in/out of vehicle
☐ grasping	☐ meal preparation	☐ eating	☐ reaching to shelves
☐ lying flat	☐ rolling over	☐ talking	☐ bending/stooping
☐ balancing	☐ kneeling	☐ chewing	☐ walking short distance
☐ jumping	☐ running	☐ biting	☐ walking long distance
☐ pulling	☐ reaching	☐ hopping	☐ walking outdoors
☐ lifting	☐ carrying	☐ squatting	☐ pushing

My leisure activities/sports: ____

My job responsibilities: ____

Other difficulties:____

Please consider your average pain over the last 5 days, and mark an X on the line below:

1————————————————————————1

No Pain at all — Severe enough for the hospital

___________ Patient's Initials

GRELOT PHYSICAL THERAPY MEDICAL HISTORY FORM

Have you been discharged from a hospital or skilled nursing facility in the last 30 days? _______________

How many times have you fallen in the past 2 years? _____If so, what happened?_____________________

Allergies: None___ Latex___ Tape/Adhesives___ other:___________________________________

How would you rate your current health? Excellent___ Very Good___ Good___ Fair___ Poor___

Please check if you have any or a history of the following conditions:

___Smoke/Chew Tobacco
Packs per day: ______
___Use of Illegal Substances
___Drink Alcoholic Beverages
Amount per day: _____
___High Blood Pressure
___High Cholesterol
___Bowel/Bladder problems
___Acid Reflux or Ulcers
___Thyroid Disorder
___Bleeding Disorder
___Seizures/Epilepsy
___Fractures
___Head Trauma
___Sleeping Difficulties
___Heart Condition: _____________

___Diabetes
___Heart Attack
___Cardiac Bypass
___Cardiac Stents
___Angina/Chest Pain
___Pacemaker
___Emphysema
___COPD
___Asthma
___Kidney Disease
___Stroke
___Depression
___Respiratory illness
___Convulsions
___Rheumatic disease
___Other: ____________________________________

___Sexually Transmitted Disease
___Osteoarthritis
___Rheumatoid Arthritis
___Osteoporosis or Osteopenia
___Metal/Plastic Implants
___Headaches or Migraines
___Dizziness or Fainting
___Cancer (site: __________________)
___Recent Infection
___Hernia
___Recent Antibacterial Medicine Use
___Consistent Steroidal Medicine Use
___Blood disease
___Vascular disease
___Women: I am pregnant.

List all previous surgeries and dates: ____
____

List all medications/supplements you are taking: ____
____

List any other Physical or Personal limitations: ____
____

To the best of my knowledge, the information provided herein is correct.

______________________________________ ____________________

Patient/Representative Date

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read and review it carefully.

This notice describes the privacy practices of Grelot Physical Therapy.

Our pledge regarding medical information.

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at our clinic. We need this record to provide you with quality care and to comply with certain HIPPA requirements. This notice applies to all of the records of your care generated by our clinic. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to make sure that your medical information is kept private.

Provide you this notice of our legal duties and privacy practices with respect to medical information about you and follow the terms of the notice that is currently in effect.

How we may use and disclose medical information about you.

For treatment: We may use your medical information to provide you with medical treatment or services. We may disclose medical information about you to hospitals and other doctors who are involved in your care. For example, we may disclose medical information to a hospital so that diagnostic tests can be schedules or we may notify a surgeon about your need for certain surgical procedures.

For payment: We may use and disclose medical information about you so that the treatment and services you receive from us may be billed for payment may be collected from you, an insurance company or a third party. For example, we may need to tell your health plan provider certain information about an office visit at our clinic so your health plan will pay us or reimburse you for the services.

For health care operations: Medical information about you at our clinic may be used and disclosed for health care operations. These uses and disclosures are necessary to run our business and make sure that our patients receive quality care. For example, members of our medical staff may use information in your health record to access the care and outcomes of your case and others similar to it. This information can then be used to measure the quality of our service and help continue to improve your care.

Appointment reminders: We may contact you as a reminder that you have an appointment for treatment at our clinic.

Treatment Alternatives: We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health Related Benefits and Services: We may tell you about health related benefits or services that may be of interest to you such as disease specific support groups or childbirth education and classes.

Individuals involved in your care or payment for your care: Our healthcare professionals may base their clinical judgment that is believed to be in your best interest, disclose information about you to a friend or family member who is involved in your medical care or who may help pay for your case.

Research: Under certain circumstances, we may use and disclose medial information about you for research purpose. All research projects however are subject to a strict approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients need for privacy of their medical information. Before we use or disclose medical information for research, the project will be approved through this research approval process. We

may however disclose medical information about you to our clinical research staff, as long as the medical information they review is limited to use by our clinic in preparation for a research project. This helps them look for patients with specific medical needs who may benefit from new treatments or procedures. We may release information that reveals who you are to researchers or others involved in your care at the clinic. If a research project is identified that may benefit you, your physician will be contacted to advise him of the availability of the study. This information will be discussed only with your physician and the researcher.

As required by law: we will disclose medical information about you when required to do so by federal state or local law.

To avert a serious threat to health or safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however; would only be to someone able to help prevent the threat.

Special Situations:

Military and Veterans: if you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers compensation: we may release medical information about you for workers compensation or similar programs accorded to applicable law.

Public Health Issues: We may disclose medical information about you for public health activities. The reason we may disclose information would be for the purpose of preventing or controlling disease, injury or disability.

Health Oversight Activities: We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we will disclose medical information about you, where required in response to a court or administrative order. We will also where required disclose medical information about you in response to a subpoena, discovery request or other lawful request, or other lawful process by someone else involved in the dispute, but only after efforts have been made through judicial process to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release medical information to a law enforcement official or other governmental representatives law enforcement purposes.

Coroners, Medical Examiner and Funeral Directors: We may release medical information to coroners, medical examiners or funeral directors consistent with applicable law to carry out their duties.

National Security and Intelligence Activities: We may release medical information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Protective Services for the President and others: We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the institution to provide you with health care. To protect your health and safety or the health and safety of others or for the safety and security of the correctional institution.

Your rights regarding medical information about you:

With regard to your medical information that we maintain, you have the right to:

- Inspect and obtain a copy of your medical information as provided for in 45CFR 164.524 Usually this includes medical and billing records but does not include psychotherapy notes. We may charge a fee for the cost of copying, mailing or other supplies associated with your request.
- Amend your medical information as provided for in CFR 164.526
- Obtain an accounting of disclosures of your health information as provided for in 45 CFR 164.528. Contact the privacy officer to make arrangements.
- Request restrictions on certain uses and disclosures of protected health information as provided for in 45 CFR 164.522CA. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to the privacy officer.
- Request confidential communications, you must make your request in writing to the privacy officer.
- Receive a copy of this notice upon request at the registration/admission desk.

Changes to this Notice: We reserve the right to change this notice. We reserve the right to make the revised and/or changed notice effective for medical information we already have about you as well as nay information we receive in the future. We will post a copy of the current notice in our clinic for your review. The notice will contain the effective date in the top right hand corner of the first page. In addition, each time you register at or are admitted at our clinic a copy of the current notice in effect will be available upon request.

To report a problem: If you believe your privacy has been violated, you may file complaint with our clinic or secretary of the department of health and human services. To file a complaint with our clinic, contact the privacy officer. All complaints must be submitted in writing. There will be no retaliation for filing a complaint.

Other uses of Medical Information:

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical about you, you may revoke that permission in writing at any time. If you revoke your permission we will no longer use or disclose medical information about you for the reason covered by your written authorization. You understand that we are unable to take back any disclosure we have already made with your permission, and that we are required to retain our records of the care that we provided you.

Submit Written Requests to the following address.

Grelot Physical Therapy

5901 Grelot Road Building B

Mobile AL, 36609

If you have any questions about this notice. Please call 251-343-1178