East and West Physical Therapy, LLC

2919 S. 120th St. – Omaha, NE 68144
Office Phone: (402) 504-3535 Cell Phone: (402) 630-9756
Fax: (402) 934-3866

OUTPATIENT THERAPY TREATMENT AGREEMENT

If physical therapy is being sought due to an accident, please indicate the _________ *and* _______ *of the accident*
Date *Time*

Patient Information

Last Name ___________________________________ First Name __________________________ Middle Initial _______
Home Address ____
City ____ State _________________ Zip Code _______________
Phone Numbers: Home: (______)______________Work: (______)_____________Cell: (______)________________
Social Security Number: _________ - _________ - ______________ Date of Birth ______ / _____ / ______
Emergency Contact Name and Phone Number(s) ____

Insurance Information:

Name of Primary Insurance Company: ____
Insured's ID Number _______________________________________ Group Number ___________________________
Plan Name and/or Plan ID Number: ___________________________ Cardholder Date of Birth ______ / _____ / ______

Responsible Party Information:

Responsible Party's Last Name ______________________ First Name _____________________ Middle Initial ______
Relationship to Patient ____
Home Address ____
City ____ State _________________ Zip Code _______________
Phone Numbers: Home: (______)______________Work: (______)_____________Cell: (______)________________
Employer's Name: ____

Referring Physician Information:

Last Name ____ First Name ____
Office Address ____
City ________________________ State __________ Zip Code _________ Phone Number (______)________________

FINANCIAL RESPONSIBILITY: I hereby guarantee payment of therapy services to East and West Physical Therapy, LLC and acknowledge receipt of the fee schedule. I understand I am responsible for payment of my account and this facility does not accept responsibility for negotiating a settlement on a disputed claim. All balances, after maximum insurance payment has been received by the facility, are due and payable upon receipt following the last insurance monies received by the facility. Interest of 1.5 % monthly will be added to all accounts that become 30 days past due. In the event this account is placed with an attorney or collection agency for collection, the undersigned agrees to pay reasonable attorney's fees, legal expenses and lawful collection costs in addition to all other sums due hereunder. **X _____ Initial**

AUTHORIZATION FOR RELEASE OF INFORMATION: The institution rendering services is hereby authorized to furnish and release, in accordance with Facility policy, such professional and clinical information as may be necessary for the completion of medical claims by valid third party agents or agencies from the medical records compiled during treatment. East and West Physical Therapy, LLC is hereby released from all legal liability that may arise from the release of said information. **X _____ Initial**

TREATMENT CONSENT: I hereby consent to the examinations, treatments and medication ordered or recommended by my attending physician and/or designated alternate. **X _____ Initial**

ASSIGNMENT AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby assign and authorize payment directly to this Facility, herein specified and otherwise payable to me, but not to exceed the Facility's regular charges for this period of treatment. I understand I am financially responsible to the Facility for charges not covered or paid by my insurance. **X _____ Initial**

Patient Signature ______________________________ Responsible Party Signature________________________________

Date ______________ Date _____________

Facility Witness Signature ____

Date ______________

East and West Physical Therapy, LLC
The patient and responsible party have received a copy of this Outpatient Therapy Treatment Agreement.

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PATIENT INFORMATION SHEET

General Information:

Last Name ________________________ First Name ____________________ Middle Initial _______

Home Address ____

City _______________________________ State __________________ Zip Code _______________

Phone Numbers: Home: (____)___________Work: (____)___________Cell: (____)_____________

Email Address: _________________________________ Date of Birth : _______________________

Month Day Year

Gender: □ Male □ Female Social Security Number: _________ - _________ - _____________

Emergency Contact Name and Phone Number(s) ____

Insurance Information:

Name of Primary Insurance Company: ____

Address: ____

City _______________________________ State __________________ Zip Code _______________

Phone Number: (____)______________ Deductible: ___________________ CoPay: ________________

Insured's ID Number ______________________________ Group Number _________________________

Plan Name and/or Plan ID Number: ____

Name of Secondary Insurance Company: ____

Address: ____

City _______________________________ State __________________ Zip Code _______________

Phone Number: (____)______________ Deductible: ______________ CoPay: _____________________

Insured's ID Number ______________________________ Group Number _________________________

Plan Name and/or Plan ID Number: ____

Responsible Party Information:

Responsible Party's Last Name _________________ First Name ________________ Middle Initial ___

Relationship to Patient ___________________

Home Address ____

City _______________________________ State __________________ Zip Code _______________

Phone Numbers: Home: (____)____________Work: (____)_____________Cell: (____)______________

Email Address: _________________________________ Date of Birth : _________________________

Month Day Year

Gender: ___ Male ____ Female Social Security Number: ______ - ______ - ______

Employer's Name: ____

Address: ____

City _______________________________ State __________________ Zip Code _______________

Phone Number: (____)_____________

Referring Physician Information:

Last Name ______________________________ First Name _____________________________________

Office Address ____

City _______________________________ State __________________ Zip Code _______________

Phone Numbers: Home: (____)___________Work: (____)____________Cell: (____)_____________

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government or private benefits to myself or to the party who accepts assignment on this claim.

Signature of Responsible Party ______________________________________ Date ___________________

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Office Financial Policy and Billing Agreement

Name (*print*): ______________________________________

Insurance Coverage:

- Patient agrees to contact Insurance Company to verify Physical Therapy benefits. You pay for your insurance. It is your responsibility to know the benefits of your policy. _____ (initial)
- Should a dispute arise on a claim, **it is generally the Patients' responsibility to clarify and resolve the dispute with the insurance company.** _____ (initial)
- If insurance *is* being filed, any deductible not yet met is **due at the time of service as well as any co-pay.** _____ (Initial)

Payment:

- If Insurance *is not* being filed, payment is expected at the time of service, _____ (initial)
- I agree to provide a 24 hour notice to cancel an appointment. Otherwise no-show charges will be assessed. _____ (initial)
- If a Patient does not show for a scheduled appointment, there is a no-show charge. First No-Show = $50, Second No-Show = $75, Third No-Show = $100. Medicaid Patients will be charged $10.00. _____ (initial)
- A service requested by the Patient, but not covered by the Patient's Insurance Plan may be arranged under a separate written agreement with the provider. _____ (initial)
- Phone calls are not billable to your insurance. Phone calls over 10 minutes are billed for the amount of time spent on the phone, at the pro-rated hourly rate. _____ (initial)
- Email - no appointments will be scheduled via email. Emails and phone calls will be responded to within 72 hours. Appointments will only be made via phone calls. _____ (initial)
- Our fees are subject to change at the discretion of the practice. A fee schedule is available upon request. _____ (initial)
- There is a $25 administration charge for checks that do not clear the bank. _____ (initial)
- Questions regarding your account should be directed to the Billing service at 709-0063.

  _____ (initial)

I certify that I have read, understand and agree to the foregoing. The undersigned is the Patient or is duly authorized by or on behalf of the Patient to execute the above and accept its terms.

____

Signature of Patient or Responsible Party Date

____

Signature of Witness Date

East and West Physical Therapy, LLC
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 review it carefully.

East and West Physical Therapy LLC, is committed to protecting your privacy and understands the importance of safeguarding your personal health information. We are required by federal law to maintain the privacy of health information that identifies you, or that could be used to identify you (known as "Protected Health Information"). We also are required to provide you with this Notice, which explains our legal duties and privacy practices with respect to Protected Health Information that we collect and maintain. This Notice describes your rights under federal law, and state law where applicable, relating to your Protected Health Information. *East and West Physical Therapy LLC* is required by federal law to abide by this Notice. However, we reserve the right to change the privacy practices outlined in this Notice and make the new policies effective for all Protected Health Information that we maintain. Should we make such a change, we will display the revised Notice in our office and make it available to you upon request.

Uses and Disclosures of Protected Health Information

Routine Uses and Disclosures of Protected Health Information for Treatment, Payment, or Health Care Operations: *East and West Physical Therapy LLC* is permitted under federal law to use and disclose Protected Health Information without your specific permission for three types of routine purposes: treatment, payment, and health care operations.

Your physical therapist will use or disclose your Protected Health Information as described below. Your Protected Health Information may be used and disclosed by your physical therapist, staff and others outside the office who are involved in your care and treatment. Following are examples of the routine permitted uses and disclosures of your Protected Health Information. While this list is not meant to be exhaustive, it should give you an idea of the everyday uses and disclosures "behind the scenes" that are essential to the care you receive.

Treatment: Your Protected Health Information can be used and disclosed by *East and West Physical Therapy LLC* for treatment purposes. For example, your Protected Health Information will be used by our physical therapist to counsel you about the appropriateness of your care. We also may disclose your Protected Health Information to provide you with information regarding possible alternative treatment options and other health-related benefits and services that we believe might interest you. For example, we may send you reminders/information about specials on current information or products that we may carry. Or, we may use your Protected Health Information to communicate with you about new or updated services and products that may enhance or improve your treatment.

Payment: Your Protected Health Information can be used and disclosed for payment purposes. For example, we may communicate your Protected Health Information to your insurance company so that it can process payment for your treatments.

Health Care Operations: Your Protected Health Information can be used and disclosed to allow us to conduct health care operations, which generally are the administrative activities that we undertake in order to operate our office. For example, we may use your Protected Health Information to evaluate the performance of our physical therapist and to engage in other quality assurance activities.

Other Permitted Uses and Disclosures of Protected Health Information: In general, we are required to obtain your specific written authorization to use or disclose your Protected Health Information for purposes unrelated to treatment, payment, or health care operations. However, there are exceptions to this general rule under which we are permitted or required to make certain uses and disclosures of your Protected Health Information without authorization. These situations include, but are not limited to:

Required by the Secretary of Health and Human Services: We may be required to disclose your Protected Health Information to the Secretary of Health and Human Services to investigate or determine our compliance with the federal privacy law.

Required by Law: We may use or disclose your Protected Health Information to the extent that the use or disclosure is otherwise required by state or federal law.

Public Health: We may disclose your Protected Health Information for public health activities, such as disclosures to a public health authority or other government agency that is permitted by law to collect or receive the information (ie., the Food and Drug Administration).

FORM CONTINUED ON REVERSE

Abuse or Neglect: If you have been a victim of abuse, neglect, or domestic violence, we may disclose your Protected Health Information to the government agency authorized to receive such information.

Health Oversight: We may disclose Protected Health Information to a health oversight agency for activities authorized by law, such as: civil or criminal investigations; inspections; licensure or disciplinary actions; or other activities necessary for appropriate oversight of *East and West Physical Therapy LLC,* government health benefit programs, or compliance with laws.

Judicial and Administrative Proceedings: We may disclose Protected Health Information in response to a court or agency order, and, in some cases, in response to a subpoena or other lawful process not accompanied by a court order.

Law Enforcement: We may disclose Protected Health Information for law enforcement purposes, such as providing information to the police about the victim of a crime.

Research: We may disclose your Protected Health Information to researchers when the research is being conducted under established protocols to ensure the privacy of your information.

Serious Threat to Health or Safety: Your Protected Health Information may be disclosed if we believe it is necessary to prevent a serious and imminent threat to the public health or safety and it is to someone we reasonably believe is able to prevent or lessen the threat.

Specialized Government Functions: We may disclose Protected Health Information for purposes related to the military or national security concerns, such as for the purpose of a determination by the Department of Veterans Affairs or your eligibility for benefits.

Worker's Compensation: Your Protected Health Information may be disclosed to comply with worker's compensation laws and other similar programs.

Other Restrictions on Uses and Disclosures of Protected Health Information: The uses and disclosures of your Protected Health Information described above are permitted or required by federal law. Some states have laws that require additional privacy safeguards above and beyond the federal requirements. Thus, if a state law is more restrictive regarding uses and disclosures of your Protected Health Information, or provides you with greater rights with respect to your Protected Health Information, *East and West Physical Therapy LLC* will comply with the state law.

Disclosures to Other Parties for Conducting Permitted Activities: *East and West Physical Therapy LLC* may conduct the above-described activities ourselves, or we may use other entities to perform those operations. In those instances where we disclose your Protected Health Information to a third party acting on our behalf, we will protect your Protected Health Information through an appropriate privacy agreement.

Other Uses and Disclosures of Protected Health Information Based Upon Your Written Consent: Other uses and disclosures of your Protected Health Information not described above will be made only with your written consent. You may revoke this authorization at any time, in writing, except to the extent that we have taken action in reliance on the consent.

YOUR RIGHTS: As a patient, you have certain rights regarding your access to, and the accuracy of, your Protected Health Information. These rights include:

You have the right to request a restriction on certain uses and disclosures of your Protected Health Information. This means that you may ask us not to use or disclose any part of your Protected Health Information for purposes of treatment, payment, or health care operations. You may also request that any part of your Protected Health Information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restrictions requested and to whom you want the restrictions to apply.

East and West Physical Therapy LLC is not required to agree to such a restriction. If we do agree, we will abide by your restriction unless we need to use your Protected Health Information to provide emergency treatment. In addition, we may elect to terminate the restriction at any time.

You have the right to request to receive information from us by alternative means or at an alternative location if you believe it would enhance your privacy.

You have the right to inspect and copy your Protected Health Information.

You have the right to amend your Protected Health Information.

You have the right to receive an accounting of certain disclosures we have made of your Protected Health Information.

East and West Physical Therapy
Receipt of Notice of Privacy Practices

I, the undersigned patient of *East and West Physical Therapy LLC* herewith certify that I have received a copy of the Notice of Privacy Practices and understand and comply with all of the regulations contained within.

____
Patient's Printed Name

____
Patient's Signature

____
Date