WELCOME

Thank you for trusting us with your therapy needs. We pledge to do our best to provide you with the finest care available.

Abbeville ***Erath***

- PATIENT INFORMATION -

Name_____ Soc. Sec. # _____
Last Name First Name Initial

Home Phone # _____ Other Contact # _____

Address_____ City_____ State_____

Zip Code_____ e-mail address_____

Sex ☐ M ☐ F Age_____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Patient Employed By _____Occupation _____

Business Address_____ Business Phone_____

Have you had any Physical Therapy or Speech Therapy at another facility this year? _____
If so, please list: _____
Are you currently receiving Home Health Services?_____

Is this a Workers Comp Case? ☐ Yes ☐ No If Yes, Workers Comp Carrier: _____
Contact Person_____ Phone Number_____
Date of Accident_____ Describe Accident_____
In which state did this accident occur?_____

Is your injury a result of a motor vehicle accident? ☐ Yes ☐ No If Yes, Name and Address of Insurance Carrier responsible for this bill _____
Date of Accident _____Describe Accident_____
In which state did this accident occur?_____

Is this a Litigation Case? ☐ Yes ☐ No If Yes, Attorney Name_____
Attorney Address_____ City_____ State_____ Zip Code_____

What physician wrote your prescription? _____

What area of the body is in need of physical therapy? _____

Whom may we thank for referring you? _____

In case of emergency who should be notified? _____ Phone _____

If patient is a minor, please fill out parental information below:

Parent/ Guardian responsible for the bill: _____
Last name First Name Initial
Address, if different from patient _____
City _____ State _____ Zip Code _____
Home Phone: _____ Work Phone: _____

- Primary Insurance -

Primary Insurance Company _____

Contract # _____ Group # _____

Subscriber's Name _____
Last Name First Name Initial

Subscriber's Soc. Sec # _____ Birthdate_____ Phone _____

Address if different from patient _____

City_____ State _____ Zip Code _____

Relationship to Patient Self Spouse Parent/ Guardian Other

Subscriber Employed By _____ Business Phone _____

- Secondary Insurance -

Is patient covered by additional insurance? ☐ Yes ☐ No

Secondary Insurance Company _____

Contract # _____ Group # _____

Subscriber's Name _____
Last Name First Name Initial

Subscriber's Social Security # _____ Birthdate _____ Phone _____

Relationship to Patient ☐ Self ☐ Spouse ☐ Parent/ Guardian ☐ Other

- Assignment of Benefits and Release -

1) I hereby assign and authorize payment of Medicare, Medicaid and other Insurance benefits otherwise payable to me, directly to Vermilion Physical Therapy for services rendered, which are not paid by me at the time of service.
2) I understand that I am ultimately responsible for payment of any and all charges for treatment received and if this assigned claim is rejected, modified or not paid within a reasonable time after it has been filed, it will be my responsibility to pay any unpaid charges in full.
3) I understand that it is my responsibility to pay for all charges incurred through a collection agency should my account not be paid in full in a timely manner and have to be turned over to such agency for collection of monies owed to Vermilion Physical Therapy.
4) I hereby authorize Vermilion Physical Therapy to provide treatment for the patient listed above, and to release any and all information pertaining to office services rendered to me by said practice, including the diagnosis and treatment rendered to me by previous physicians, hospitals, or other medical facilities/ personnel.

Date: _____ Signature: _____

Please answer the following questions.

PAST MEDICAL/SURGICAL HISTORY - List all medical conditions you have been diagnosed with and surgeries you have had within the last 10 years.

_____

_____

_____

_____

Answer yes or no to the following:

Pacemaker Placement	☐ yes	☐ no
Cancer	☐ yes	☐ no
Spinal Fusion	☐ yes	☐ no
Joint Replacement	☐ yes	☐ no
Rheumatoid Arthritis	☐ yes	☐ no
Heart	☐ yes	☐ no
Kidney Disease	☐ yes	☐ no
Joint Disease	☐ yes	☐ no
Lung Disease	☐ yes	☐ no
Diabetes	☐ yes	☐ no
HIV	☐ yes	☐ no
Hepatitis	☐ yes	☐ no
Unexplained weight loss	☐ yes	☐ no

Women: Are you currently pregnant or think you may be? ☐ yes ☐ no

MEDICATIONS - List all medicines currently taking.

_____

_____

_____

_____

_____

GENERAL HEALTH: _☐_ GOOD _☐_ FAIR _☐_ POOR

Print Form

Vermilion Physical Therapy, Inc.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICALINFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

We respect the privacy of your personal health information and are committed to maintaining confidentiality. This notice applies to all health information and medical records related to your care that our office has received or created. This notice informs you of the possible uses and disclosures of your health information. It also informs you of your rights and our obligations regarding your personal health information.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, attorney or from other companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Healthcare Operations. Your health information may be used as necessary to support the day-to-day activities and management of **Vermilion Physical Therapy**. For example, information on the services you received may be used to support budgeting and financial reporting, activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Communication with Family. Health professionals, using their best judgment, may disclose to a family member, other relative, a close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Business Associates. We may disclose your health information to our business associates who have entered into a business agreement with our office when this information is necessary for providing your care (ie: collection agencies, attorneys and billing software companies.)

Other Uses and Disclosures Require Your Authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment Reminders. Your health information will be used by our staff to call you regarding an appointment time reschedule, etc.

Patient Rights
Although your health record is the physical property of the healthcare office that compiled it, the information belongs to you. These rights include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information – copies will be made at a charge of $1.00 per page for up to 25 pages, and $.50 for each additional page thereafter, and postage if you want the copies mailed to you
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Vermilion Physical Therapy Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.
We are also required to abide by the privacy policies and practices that are outlined in this notice.
We reserve the right to change our privacy practices are permitted by law.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Vermilion Physical Therapy
Attn: Human Resources
2626 North Drive
Abbeville, LA 70510

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

For further information concerning our privacy practices contact:

Vermilion Physical Therapy
(337) 893-4500

Effective Date
This *notice* is effective on or after April 14, 2003.