nmotion
Hand and Physical Therapy

NEW PATIENT FORMS

PATIENT INFORMATION **TODAY'S DATE** _____

Last Name_____ First_ _____ Social Security_____ - ____ - _____

Home Address_____ City_____ State_____ Zip_____

Date of Birth_____ Home Phone_____ Cell Phone_____ Sex M F

Email Address_____ Marital Status: S M D W

Referring Physician _____Primary Physician _____

Emergency Contact_____ Phone_____ Relation _____

INSURANCE INFORMATION

Policy Holder (If Other Than Self)_____

Relationship to Patient _____SSN_____-____-_____ DOB_____

Insurance Company_____ Phone _____

Policy Number_ _____ Group Number _____

Responsible Party Employer_____ Phone _____

Work Address _____City_ _____ State _____ Zip_____

Secondary Insurance _____ Phone _____

Policy Number_____ Group Number _____

Medicare Patients: Are you receiving home care services? Yes or No

Have you received Therapy Services this year? Yes or No

** As of January 1, 2013 Medicare limits all physical, occupational and speech therapy to $1,900 per calendar year. You will be responsible for any therapy services provided beyond the Medicare limitation.**

Medicare Patients Please Initial _____

INFORMATION ABOUT YOUR NEED FOR THERAPY

Date of Injury or Onset of Problems_____

Tell us about your injury or condition_____

Is this injury the result of an Auto Accident? Yes or No

If Yes, how are you filing: __ Auto Insurance __Medical Insurance __Self Pay __Through a 3rd Party

Did this injury occur at work? Yes or No

If Yes, was the injury reported and filed under Workers Compensation? Yes or No

Carrier Company: _____ Case Number: _____

Case Manager: _____Phone: _____ Ext: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR CLINIC? (CHECK ALL THAT APPLY)

Advertisement _____ Been Here Before_____ Doctor_____ Friend_____

Family _____ Insurance Provider _____ Newspaper _____ Phone Book _____

Website _____ Other _____

PATIENT MEDICAL HISTORY

Please check if you have or ever had any of the following:

☐ High Blood Pressure	☐ Presently Pregnant	☐ Hernia	☐ Diabetes
☐ Heart Surgery	☐ Balance Problems	☐ Asthma	☐ Anxiety
☐ Thyroid Problem	☐ Arthritis	☐ Dizziness	☐ Headaches
☐ Heart Attack	☐ Pacemaker	☐ Kidney problems	☐ Hearing Loss
☐ Vascular Disease	☐ Heart Disease	☐ Osteoporosis	☐ Stroke

Please list any other significant past medical history and types of surgeries_____

_____

Please list known allergies _____

Current Medications_____

_____

Have you received any of the following medical services for this injury/episode:

☐ Orthopedist	☐ Massage Therapist	☐ X-Rays	☐ Emergency Room Care
☐ Neurologist	☐ Chiropractor	☐ MRI	☐ Myelogram
☐ Physical Therapist	☐ Occupational Therapist	☐ CT Scan	☐ EMG / NCV

☐ Other _____

Please circle your current **PAIN LEVEL** on a scale of 0 – 10 (0=no pain and 10=pain that requires emergency assistance) 0 1 2 3 4 5 6 7 8 9 10

Please provide us with any other information that would assist us in your care: _____

_____

POLICY DISCLOSURES

Cancellation or No-Shows - Please provide us with atleast 24 hours notice or you will be billed a charge of $25.

In order for nMotion Hand & Physical Therapy to provide you with the best care possible, we ask that you make every effort to keep your scheduled appointments and arrive in a timely manner. Three (3) consecutively missed appointments will be considered a self discharge and a discharge summary will be provided to your physician and/or case worker. Patients that arrive 15 or more minutes late may be asked to reschedule their appointment.

Insurance Benefits or Coverage – It is the patient/insured person's sole responsibility to know their outpatient physical therapy benefits. nMotion Hand & Physical Therapy is not required to contact your insurance company but does so as a courtesy. The information received is not a guarantee of payment. Patients are expected to know their plan benefits and limitations prior to their initial visit. As a courtesy payment plans are available upon request. Please discuss with the front office prior to treatment.

Co-Payments, Co-Insurance and Deductibles are to be paid at time of service.

Prescriptions – A prescription for physical therapy signed by a Georgia Licensed Physician is required for treatment and it is the patient's responsibility to ensure that it is up to date and valid

Medical Supplies – We do offer medical supplies and rehab products for purchase. Please note we do not bill insurance for these products.

CONSENT FOR TREATMENT AND BENEFITS

My signature is required below to authorize treatment. My signature also authorizes the release of my medical information (including but not limited to my physician, insurance company, employer, school, related health care provider, nurse, case manager, attorney, assignees, beneficiaries, and all other related persons to my treatment) that is needed to process my claim. I also agree to a direct assignment of my benefits to nMotion Hand & Physical Therapy where a claim has been filed, the payment of medical benefits directly to this practice for services rendered, and to comply with the policies previously stated. We reserve the right to change our policies without prior notice.

I am aware of my diagnosis and voluntarily consent to treatment at this practice. No guarantees have been made to me about the outcome of care provided at this practice. I agree to pay for the services rendered and to cooperate in providing information necessary to process my claim(s) with third-party payers. Where the law or my insurance contract does not prohibit payment by me, I accept responsibility to pay any and all of my account balances (even if the balance differs from the benefit verification form as said form is not a guarantee for coverage). A photo copy or carbon copy of this agreement shall be as effective and valid as the original. All information provided on this document is accurate to the best of my knowledge.

Signature_____ Date_____

PRIVACY PRACTICES ACKNOWLEDGEMENT

1) I have reviewed a copy of **nMotion's** Privacy Practices. I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and healthcare operations. I also grant permission for this practice and its affiliates to obtain information from my physician and other medical professionals as it relates to my treatment. ☐ **Yes** ☐ **No**

2) I agree to the open gym area used by **nMotion.** ☐ **Yes** ☐ **No**
(A private treatment room is available upon request).

3) I authorize **nMotion** to send me newsletters via email. ☐ **Yes** ☐ **No**

4) I authorize **nMotion** Therapy to call me at my home, on my cell phone or email me with regards to my appointments. ☐ **Yes** ☐ **No**

Signature _____Date_____
(Of Patient or Guardian)

Documentation of Good Faith

The patient identified above was made aware of the availability of the Privacy Notice on this date. A good faith effort has been to obtain a written acknowledgment of this. However, acknowledgement has not been obtained because:

__ Patient refused to sign
__There was a medical emergency
__ Patient was unable because:_____
__ Other reason:_____

Employee's Name_____ Employee's Signature _____

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NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect November 1, 2007 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and applicable law permits the terms of this Notice at any time, provided such changes. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you. n motion Hand & Physical Therapy utilizes an open treatment facility. It is possible that while under our care an unauthorized individual may have access to your protected health information via overheard verbal communications. We will do everything possible to protect your rights to privacy and confidentiality.

Electronic Communication: There may be instances when **nMotion** communicates some of your protected health information via electronic means, either to you, your physician, your insurance company, your billing company or another provider regarding your care. nMotion cannot guarantee privacy for e-mail communication.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose, to authorized federal officials, health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $ .10 (ten cents) for each page, $15.00 (Fifteen dollars) per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before November 1, 2007. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us at:

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