REAPER
PHYSICAL THERAPY, INC.

Patient Information (Please Print): □ M □ F DOB:_____

Patient Name: _____
(Last, First, MI)

Maiden/Previous Name: _____ SSN: _____

Status: □ Child □ Single □ Married □ Divorced □ Widowed

Mailing Address: _____
(Street, PO Box, etc.)

_____ _____
(City, State, Zip) (Home Address or Same)

Phone: (H)_____ (C)_____

Employer: _____ Name of Bank: _____

Primary Care Physician: _____ Referring Doctor: _____

Spouse or Custodial Parent Information: □ **Spouse** □ **Parent**

Spouse/Custodial Parent _____
(Last, First, MI)

□ M □ F DOB:_____ SSN: _____

Mailing Address: _____
(Street, PO Box, etc.)

_____ _____
(City, State, Zip) (Home Address or Same)

Phone: (H)_____ (C)_____

Employer: _____ Name of Bank: _____

Emergency Contact

Name:_____
(Last, First, MI)

Phone: (H)_____ (C)_____

Relationship: _____ Address: _____

Reaper Physical Therapy, Inc.

AUTHORIZATION TO BILL INSURANCE & CONSENT FOR TREATMENT

Do not sign this agreement before you read and agree to the conditions set forth herein.

I authorize treatment of the patient named above and agree to pay all fees and charges for such treatment. I agree to pay all charges shown by statements promptly, unless credit arrangements are agreed upon in writing. Charges shown by statement are agreed to be correct and reasonable unless protested in writing within thirty (30) days of billing date. In the event legal action should become necessary to collect an unpaid balance due for services rendered to my family or me, I/we agree to pay reasonable attorney's fees or other such costs as the court determines proper. I hereby authorize the release of medical information to insurance carriers concerning my illness and treatment and I hereby assign to Reaper Physical Therapy, Inc. all payments for therapy rendered to my dependent or me.

I also authorize the release of any medical or financial information necessary to process my claim(s). This release also includes CMS (centers for Medicare or Medicaid Services). I authorize and request payment of medical benefits directly to Reaper Physical Therapy, Inc. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me in writing. I agree that a photocopy of this form may be used in place of the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I also authorize any insurance company, prepayment organization, employer, hospital, or physician to release all information with respect to myself or any of my dependents that may have a bearing on the benefits payable under this or any plan providing benefits or services. I certify the information is correct and true to the best of my knowledge.

COMPLIANCE AGREEMENT

At Reaper Physical Therapy, Inc. our goal is to provide our patients with the highest quality of care possible. To ensure our patients receive the maximum benefit from physical therapy, speech therapy, and occupational therapy, it is essential that they fully comply with the treatment frequency established by the therapist and the patient's physician in the patient's plan of care. If a patient misses 3 visits within a 2 week period, we will send a letter of non-compliance to the patient's referring physician and there is a chance that the appointment time will be given to another patient. Thank you for your cooperation in achieving consistent patient care.

PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this physical therapy office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this physical therapy office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations, the physical therapist has the right to refuse to give care.

I have read the information above and I agree to these policies and procedures.

_____ _____

Signature Date

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PHYSICAL THERAPY, INC.

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I authorize the use/disclosure of my health information to the following individuals:

1)	Name:		Relationship:		Phone:	
2)	Name:		Relationship:		Phone:	
3)	Name:		Relationship:		Phone:	
4)	Name:		Relationship:		Phone:	
5)	Name:		Relationship:		Phone:	

1. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.
2. I understand that Reaper Physical Therapy, Inc. may be paid for the costs of copying the information to be released.
3. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or obtain a copy of any information used/disclosed under this authorization.
4. I understand that I may revoke this authorization in writing at any time by delivering a copy of my revocation to Reaper Physical Therapy, Inc. except to the extent that action has been taken in reliance on this authorization.

_____ _____

Signature of Patient or Representative Date