360 THERAPY

ALL AROUND EXCELLENCE

54033 Hwy 1062, Suite B
Loranger, LA 70446
Phone: (225) 209-7140 Fax: (225) 567-6847

PATIENT INFORMATION

Title: _____ **Name:** _____
First MI Last

Mailing Address: _____
Street City State Zip

DOB: _____ **Gender:** MALE ☐ FEMALE ☐ **SSN:** _____ **DL #:** _____

Home Phone: _____ **Cell Phone:** _____ **Work/Other:** _____

Email: _____ **Preferred Contact:** HOME ☐ CELL ☐ WORK/OTHER ☐ EMAIL ☐

Which method of contact would you prefer for appointment reminders? CALL ☐ TEXT ☐

Which number would you like us to use for your appointment reminders? HOME ☐ CELL ☐ OTHER ☐

Employed: YES ☐ NO ☐ **Employer Name:** _____ **Phone:** _____

Referring Doctor: _____ **Phone:** _____

Spouse's Name: _____ **Spouse's DOB:** _____

How did you hear about us? _____

EMERGENCY CONTACT

Name: _____ **Phone:** _____ **Relation to Patient:** _____

PAYMENT INFORMATION

Who is responsible for the bill? **Name:** _____ **Relation to Patient:** _____

Address: _____
Street City State Zip

Signature of Person Responsible for Bill: _____

THERAPY HISTORY

Have you had therapy this year? YES ☐ NO ☐ **If yes, which type(s)?** PHYSICAL ☐ OCCUPATIONAL ☐ SPEECH ☐

Where was therapy performed? _____ **When?** _____

AUTHORIZATION & SIGNATURE

I hereby authorize the release of any medical information necessary to process claims. I also authorize direct payment of my medical benefits to 360 Therapy for services provided. I understand that I am financially responsible for any non-covered services.

_____ _____
Patient/Parent or Guardian Signature **Date**

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INJURY AND MEDICAL HISTORY

Name: _____ **Date:** _____

Date of injury or when symptoms began: _____

Injury was incurred by:

Auto _____
School Sport _____
Work _____
Other _____

Describe your symptoms or pain:

_____
_____
_____
_____

Did you have surgery for this condition? _____

Date of Surgery: _____

Allergies? _____

Please check any of the following conditions that apply to you:

- ☐ Asthma: _____
- ☐ Cancer Type: _____
- ☐ Diabetes Insulin? Yes No
- ☐ Seizures: _____
- ☐ Stroke: _____
- ☐ High Blood Pressure: _____
- ☐ Pacemaker: _____
- ☐ Defibrillator: _____
- ☐ Other: _____
- ☐ Pregnant: _____
- ☐ Osteoporosis: _____
- ☐ Rheumatoid Arthritis: _____
- ☐ Shingles: _____
- ☐ Heart Disease: _____
- ☐ Hepatitis: _____
- ☐ Infectious Disease: _____
- ☐ Autoimmune Disease: _____
- ☐ Other Recent Surgery: _____

Please list any medications you are currently taking:

1. _____
2. _____
3. _____
4. _____
5. _____

What activities are painful or difficult to do because of your injury?

_____
_____
_____
_____
_____

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Consent to Treat, Release of Information, and Financial Agreement

I. CONSENT TO TREATMENT

For and in consideration of the medical treatment, which I may receive while a patient of 360 Therapy, from the employee staff for providing physical therapy and/or sports medicine services or supplies. I either severally or collectively consent to treatment, voluntarily and knowingly, by me if of age and competent of for me, if a minor or incompetent, by my parents, guardian or nearest relative, as the case may be, to the said members of 360 Therapy employees, or any of them severally or collectively, to carry out or cause to be carried out such medical treatment, as prescribed or ordered by my physician.

II. MEDICAL RELEASE OF INFORMATION

For the purpose of expediting payment of my account and processing of benefit claims resulting from my physical therapy and/or sports medicine services or supplies. The herein after listed Health Care providers at 360 Therapy, my prescribing or consulting physicians or their insurers, I hereby expressly waive my right and privilege under Louisiana Revised Statute 12:3734 (said statute) and authorize the release of my patient information directly to my insurer(s), worker's compensation carrier, liability insurer, Preferred Provider Organization (PPO), Medicare, medical Physician(s), attorney or other medical compensation benefit provider.

III. AGREEMENT FOR PAYMENT

In consideration of the services, I/we agree am/are solitarily liable to 360 Therapy, for and hereby guarantee the payment of all facility charges incurred in the treatment of patient in accordance with the orders of the patient's prescribing or consulting physician(s), including any facility charge not paid, for any reason, by any payer or insurance company. I/we further agree that payment is due in full within 45 days of the patient discharge and that interest at the rate of 11% per annum may be assessed against the balance remaining after payment is due as well as attorney fees of 25% of the principal and interest due of the account is referred to any attorney for collection. If a balance cannot be paid in full after 45 days of patient discharge, I (Patient/Guardian) agree to a payment schedule $40 per month if my balance is greater than $1000. I understand that 360 Therapy will bill my primary and secondary insurance (if any). I also designate 360 Therapy to file for reconsideration should my primary and secondary insurance deny payment. I request that payment of authorized benefits be made to 360 Therapy for physical therapy and/or sports medicine services or supplies on me/my family member's behalf.

By signing below, you are stating that you have read the above,
you understand all statements and policies, and agree to all terms.

Patient Signature	Patient Name *(Please Print)*	Date
Guardian/Representative Signature	Relation to Patient	Date

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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 April 4, 2016 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. 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.

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 this 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 with 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 and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up x-rays or similar 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 institutions or law enforcement officials having lawful custody of protected health information of an 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 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 $.90 per page and $20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. 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 prior to April 4, 2016. 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.

Restrictions: 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 emergency).

Alternative Communication: 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 payment 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 website 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.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: Melissa Tate, PT or Richard Wale, PTA
Phone: (225)209-7140
Fax: (225)567-6847
Address: 19089 Florida Blvd., Albany, LA 70711

Patient Signature	Patient Name *(Please Print)*	Date
Guardian/Representative Signature	Relation to Patient	Date