

Dear New SCAR Patient,

Thank you for choosing Sports Conditioning and Rehabilitation for your physical therapy needs. We know that there are many choices and we appreciate your confidence in us.

To make the most of your physical therapy experience, we have provided you with all the information you will need to make your time with us the best it can be.

Please take the time to read **all** of our attached policies and fill out the following form(s) completely **prior** to your scheduled appointment. *You are responsible for knowing all of the information in the policy pages.*

On the day of your appointment, please bring the following:

- Completed form(s)
- Insurance Card
- Prescription for physical therapy
- Free flowing clothing that will allow you to move easily

When you arrive for your appointment, you will be asked to complete a short computer health history and simply sign one more form. Arriving 10 minutes early will give you the time necessary to complete this form and be ready for your appointment.

Sincerely,

*The Physical Therapy Staff*

## Welcome to Sports Conditioning and Rehabilitation

We are pleased that you have chosen **Sports Conditioning and Rehabilitation, (SCAR)** for your physical therapy needs. You will find that we provide unsurpassed individualized patient care in a warm caring and professional environment. At SCAR, we are uniquely qualified to help you move through the full continuum of wellness from rehabilitation of your injury or disability to the promotion of injury prevention and leading a full healthy lifestyle.

To better serve you, please observe the following guidelines and policies so that we at *Sports Conditioning and Rehabilitation* can provide you with the highest quality of care and service.

- **Schedule your appointments ahead of time to ensure you get a time that works well in your day.**
  - ◆ Our physical therapy hours are 7:00 am to 6:00 pm Monday - Thursday and 7:00 am to 4:00 pm Friday
  - ◆ Upon your arrival, you will need to sign the *blue* sign in sheet with your arrival time and check in with the receptionist or one of our staff.
- **Be on time**
- **Cell phones should be placed on silent or vibrate and put in a pocket or purse.**
- **Adhere to the recommended number of treatments and to your program**
  - ◆ It is vital that you complete the prescribed number of treatments for your physical therapy. This is an essential component of your progress.
  - ◆ Because we care so much about you we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.
- **Dress for Exercise**
  - ◆ Be prepared to exercise and move easily with loose fitting, comfortable clothing. If needed we do have a locker room to change in and store your clothes. Please bring a lock if you want to lock your locker.
- **Be considerate of our physical therapists time and keep your scheduled appointments**
  - ◆ We at SCAR want to provide the best possible care for our patients' and attending scheduled appointments is a necessary part of the treatment process.
  - ◆ If you need to change or cancel your scheduled appointment time, please call SCAR as early as you know you will miss your appointment as possible. **A 24 hours notice is required for all cancellations and rescheduled appointments.**
  - ◆ In an instance of a cancellation or no show without 24 hours notice to a scheduled appointment, we reserve the right to charge a \$50 fee.
  - ◆ We will do everything we can to enable you to reschedule your appointments to fit your needs.
  - ◆ Patients and clients who are habitually late, or who fail to call and cancel missed appointments will lose the opportunity to schedule in advance and will only schedule twenty four (24) hours or less in advance.

These guidelines are in the best interest of you, and all of our patients in order to maintain our excellent level of care and service.

Thank you very much in advance for your cooperation and understanding.

*The Staff at SCAR*

## FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing Sports Conditioning and Rehabilitation as your health care provider. We are committed to providing you with a successful treatment program. The following is a statement of our Financial Policy and your agreement to follow our policy, which we require you to read and sign prior to your Physical Therapy Evaluation or treatment.

**PRIVATE INSURANCE PLANS:** All charges for services incurred by you, our patient, is your responsibility and will be expected to be paid in full. We will be happy to accept assignment of insurance benefits and submit claims to your insurance company as a courtesy to you. Please provide us with a copy of your insurance card.

- **Co-payments, co-insurance and any fees applied to your deductible are due at the time of service.** Our office staff will give you an estimate of how much each visit will be. "It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments." This is mandated by the federal government. *For full details on these laws please ask our receptionist.*
- It should be understood that you are financially responsible for all insurance benefits and/or eligibility that are not approved by your Health Insurance Plan, for all charges related to services provided to me or my dependents.
- If you choose to purchase medical supplies, please understand that these items are **not returnable**, and payment is expected at the time of purchase

**MEDICARE:** We **do** accept assignment on Medicare patients. This does not mean that Medicare pays your bill in full. Medicare patients must pay their yearly deductible and are responsible for any portion that their secondary does not cover. We will bill the secondary insurance for you. Effective January 2009, Medicare only allows \$1,840.00 per year for physical therapy treatment. There are some exceptions for certain diagnosis codes. Please check with the billing department to see if your diagnosis falls under the exceptions outlined by Medicare. Anything over this amount is the responsibility of the patient, if the secondary does not pick up the charges. If you choose to purchase medical supplies, please understand that these items are **not returnable**, and payment is expected at the time of purchase.

**OUR CHARGES:** Our charges vary depending on the complexity of the diagnosis, the amount of procedures needed for your rehabilitation and the time required for your therapy sessions. Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area.

INITIAL EVALUATION	\$128.00-\$328.00
THERAPY CHARGES per visit	\$84.00-\$218.00

**CASH POLICY:** For patients without insurance coverage, for those we are not preferred providers, or those who have exhausted their physical therapy benefits, we offer a cash discount **if paid at the time of service.** We provide this option to make your healthcare accessible and affordable.

**CANCELLATION/NO SHOW POLICY:** Because it is very difficult to fill an open physical therapy appointment at the last minute, we would appreciate twenty-four hours for consideration of the therapist's time. All patients who need to change or cancel their scheduled appointment times are expected to call SCAR and cancel their appointment at least 24 hours prior to their scheduled appointment. We reserve the right to **bill a \$50 fee for each appointment missed without prior notification.** Please remember to write down scheduled appointments to avoid this fee.

*Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.*

## Summary of Notice of Privacy Practices

A new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") goes into force on April 14, 2003. We are required to give you a printed copy of our Notice of Privacy Practices. For your convenience, we are providing this brief summary. Each section has a corresponding section in our full Notice, which we encourage you to read in its entirety. We are required to ask you to sign a one-time acknowledgment that you have received our full Notice.

**Your Rights as a Patient.** You have many new and important rights with respect to your protected health information. These are summarized below and described in detail in our full Notice of Privacy Practices.

**Use of Protected Health Information.** We are permitted to use your protected health information for treatment purposes, to facilitate our being paid, and to conduct our business and evaluate the quality and efficiency of our processes. Also, we are permitted to disclose protected health information under specific circumstances to other entities. We have put into place safeguards to protect the privacy of your health information. However, there may be incidental disclosures of limited information, such as overhearing a conversation, that occur in the course of authorized communications, routine treatment, payment, or the operations of our practice. HIPAA recognizes that such disclosures may be extremely difficult to avoid entirely, and considers them as permissible. For entities that are not covered under HIPAA to which we must send protected health information for treatment, payment, or operational purposes, we require that they sign a contract in which they agree to protect the confidentiality of this information.

**Disclosures of Protected Health Information Requiring Your Authorization.** For disclosures that are not related to treatment, payment, or operations, we will obtain your specific written consent, except as described below.

**Disclosures of Protected Health Information Not Requiring Your Authorization.** We are required by state and federal law to make disclosures of certain protected health information without obtaining your authorization. Examples include mandated reporting of conditions affecting public health, subpoenas, and other legal requests.

**Communication to You of Confidential Information by Alternative Means.** If you make a written request, we will communicate confidential information to you by reasonable alternative means, or to an alternative address.

**Restrictions to Use and Disclosure.** You may request restrictions to the use or disclosure of your protected health information, but we are not required by HIPAA to agree to such requests. However, if we do agree, then we are bound to honor your request. In the course of our use and disclosure of your protected health information, only the minimum amount of such information will be used to accomplish the intended goal.

**Access to Protected Health Information.** You may request access to or a copy of your medical records in writing. We will provide these within the time period specified, unless we are forbidden under HIPAA or by applicable state law to provide such records. If we deny access, we will tell you why. You may appeal this decision, which, under specified circumstances, will be reviewed by a third party not involved in the denial.

**Amendments to Medical Records.** You may request in writing that corrections be made to your medical records. We will either accept the amendments, and notify appropriate parties, or deny your request with an explanation. You have rights to dispute such denials and have your objections noted in your medical record.

**Accounting of Disclosures of Protected Health Information.** You may request in writing an accounting of disclosures of your protected health information. This accounting excludes disclosures made in the course of treatment, payment, or operations, and disclosures that were made as a result of your written authorization.

**Other Uses of Your Health Information.** Optional uses, as permitted under HIPAA, are listed in our complete Notice of Privacy Practices.

**How to Lodge Complaints Related to Perceived Violations of Your Privacy Rights.** You may register a complaint about any of our privacy practices with our Privacy Official or with the Secretary of Health and Human Services without fear of retaliation, coercion, or intimidation. For a full copy please ask your physical therapist.

## PATIENT INFORMATION

Thank you for choosing our office. In order to serve you properly, we need the following information.  
Please be assured that all information will be kept confidential.

Appointment Date:

Last Name	First Name	Date of Birth	M/F
Home Phone	Cell Phone	E-mail	
Address	City	State	Zip Code
SSN#	Marital Status	Spouses Name	
Employer		Work Phone	
Business Address	City	State	Zip Code
Occupation			
Referring Doctor		Injured Area	
How did you hear about us?			
<i>Person to contact in case of emergency:</i>		<i>Phone (c h w)</i>	
<b>RESPONSIBLE PARTY INFORMATION</b>			
Person Responsible		Relationship to Patient	
Address		Home Phone	
Drivers License #		Birth Date	
<b>INSURANCE INFORMATION</b>			
Insurance Company		Telephone number	
Name of Insured		Date of Birth	
Group #		I.D. #	
<i>Do you have additional Insurance Information?</i>	Yes No	<i>If yes, please complete the following:</i>	
Insurance Company		Telephone number	
Name of Insured		Date of Birth	
Group #		I.D. #	
<b>Authorization for Treatment and Release of Information</b> <p>I grant permission for all physical therapy treatment and procedures deemed necessary by my physician and set forth by my physical therapist.</p> <p>I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to Sports Conditioning and Rehabilitation.</p>			
Patient/Guardian signature			Date



*The following section is for*  
**High School/Collegiate Athletes Only**

We would like to keep the athletic trainer and/or coach at the high school and/or college you attend updated on your progress or program at SCAR. Please provide the following information:

Athletes Name: \_\_\_\_\_

High School/College: \_\_\_\_\_

Grade: \_\_\_\_\_

Athletic Trainer: \_\_\_\_\_

Coach: \_\_\_\_\_

Sport (s): \_\_\_\_\_

Is there anyone else you would like us to talk to regarding your progress or program at SCAR? (ie: club coach, parent –if over 18)  
Please provide name and phone numbers

Did your school or trainer from school tell you about SCAR?    Yes        No  
If no, how did you hear about our program?    Please circle:    Family member        Friend        Doctor        Other

Name of referral \_\_\_\_\_

I give my permission to the athletic trainers and physical therapists at SCAR to communicate with any of the persons named above. By signing below I also give my permission to release my athletic training or physical therapy information and records.

\_\_\_\_\_  
Student Athlete Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature (If athlete is under the age of 18)