Fossitt Therapy Services, Inc.

2015 S. Maple Avenue
Sanford, FL 32771

Please Complete the Following Information

First Name | Middle Initial | Last Name | Date of Birth

Address | City | State | Zip Code

Home Phone | Work Phone | Cell Phone

Sex: ❑ Male ❑ Female

Email | Social Security #

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

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Past Medical History (Please check any past/current conditions.)

- ❑ Asthma / Bronchitis
- ❑ High Blood Pressure
- ❑ Cancer
- ❑ Diabetes
- ❑ Gout
- ❑ Arthritis
- ❑ Heart Disease
- ❑ Hernia
- ❑ High Cholesterol
- ❑ HIV Positive
- ❑ Blood Clot / Emboli
- ❑ Anemia
- ❑ Osteoporosis
- ❑ Migraine Headaches
- ❑ Infectious Diseases
- ❑ Pacemaker
- ❑ Sleeping Problems
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Emotional / Psychological
- ❑ Past Surgeries
- ❑ Neck Pain / Surgery
- ❑ Back Pain / Surgery
- ❑ Shoulder Pain / Surgery
- ❑ Elbow Pain / Surgery
- ❑ Wrist/Hand Pain / Surgery
- ❑ Hip Pain / Surgery
- ❑ Knee Pain / Surgery
- ❑ Ankle/Foot Pain / Surgery

Referring Physician/Other Physicians:

Routine Medications:

List all Medications & strength you are currently taking:

I give permission to Fossitt Therapy Services, Inc. to release information to my insurance company, attorney, assignees and or beneficiaries.

I authorize payment directly to Fossitt Therapy Services, Inc. for services I receive.

Patient Signature

Date Form Completed

FOSSITT THERAPY SERVICES INC.

Notice of the Privacy Practices of Fossitt Therapy Services, Inc. Effective date: April 15, 2003

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. A signed copy of this notice will be kept in your chart.

Each time you visit a healthcare provider a record of your visit is made. Typically, this record contains your symptoms/chief complaints, examination and test results, diagnosis, treatment received, a plan for future care or treatment and may sometimes include billing related information. Your personal doctor or referring doctor may have different policies or notices regarding the doctor's use and disclosure of your health information created in the doctor's office or clinic.

Our Responsibilities:

We are required by law to maintain the privacy of your health information and provide you a description of our privacy practices. We will abide by the terms of this notice.

Uses and Disclosures:

How we may use and disclose Health Information about you.
The following categories describe examples of the way we use and disclose health information.

For Treatment: We may use health information about you to provide treatment and services. We may disclose health information about you to doctors, nurses or other health care providers who are involved in taking care of you at our clinic. For example: A PT/OT treating you for a broken hand may need to know if you have diabetes because diabetes may slow the healing process. Different departments of the clinic may also share health information about you in order to coordinate different things you may need such as prescriptions for continued care, durable medical supplies such as TNS unit, home paraffin unit, splints or braces. We may also provide your physician or health care provider with copies of various reports that should assist him or her in treating you.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your therapy so they will reimburse you for the treatment. We may also attempt to contact your health plan about a supply you are going to receive to determine whether your plan will cover it.

For Health Care Operations: Members of the medical staff and/or a quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. We may also combine health information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses and therapist students for educational purposes. We may combine information we have with other clinics to see where we can make improvements. However, it is important to note that any information that specifically identifies you in records would be removed prior to using the information for health care operations to protect your privacy. Example: 37 yr old male software engineer presents with repetitive strain injury that he relates to keyboarding would be used instead of. Mr. John Doe is a 37-year-old male who works at Apple as a software engineer etc.

We may also use and disclose health information:

- To business associates we have contracted with us to perform an agreed upon service and billing for it. Examples: TNS/Interferential unit, home traction equipment, splints.
- To remind you that you have an appointment for medical care.
- To assess your satisfaction with our services
- To tell you about possible treatment alternatives.
- To tell you about health-related benefits or services.
- For conducting training programs or reviewing competence of healthcare professionals.
- When disclosing information, primary appointment reminders and billing/collections efforts we may leave messages on your answering on your answering machine or voice mail.

Business Associates: There are some services provided in our organization through contracts with business associates. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you, your insurance company or a third party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Please sign on other side

Individuals Involved in Your Care or Payment for Your Care: We may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your care. In addition, though we are certainly not anticipating it, in the event of a disaster we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status or location.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the **Right to:**

- **Inspect and Copy:** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records.
- **Amend:** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the clinic.
- **Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. **We are not required by law to agree to your request.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
- **Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you at work instead of your home. The clinic will grant requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the clinic and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.
- **A Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask for a copy of this notice at any time.

To exercise any of your rights, please obtain the required forms from the Privacy Official and submit your request in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will always include an effective date. In addition each time you return to our clinic for a new problem you will be given a copy of the current notice that is in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the practice owner by the following the process outlined in the clinic's Patient Rights documentation. You may also file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you and documented in the clinic.

I have read and received a copy of the Privacy Practices of Fossitt Therapy Services, Inc.

Print Name: _____ **Date:** _____

Signature _____

FOSSITT THERAPY SERVICES INC.
2015 S. Maple Avenue
Sanford, FL 32771

PATIENT CONSENT

COMPLETE FOR ALL PATIENTS

PRINT PATIENT'S NAME: _____ **DATE:** _____

CONSENT FOR TREATMENT:

I hereby consent to and authorize Fossitt Therapy Services, Inc. and my clinician(s) to assess, treat and/or for Fossitt Therapy Services, Inc. to perform services for me as prescribed by my physician(s) in connection with my diagnosis of _____. Such treatment includes all therapeutic treatments that may be considered advisable and/or necessary in the judgment of the prescribing clinician(s). This Consent is intended as a waiver of liability or any claim of unauthorized treatment.

PATIENT'S SIGNATURE: _____ **DATE:** _____

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CANCELLATION - NO SHOW POLICY

Our goal is to provide high-quality individualized care. In an effort to continue to meet all patients' needs, our cancellations/re-scheduling/no-show policy is as follows:

All cancellations/re-scheduling MUST be made 24 hours prior to your appointment time or a $25 fee will be required to resume treatment.

A $25 fee will be applied to all no-show appointments to resume treatment.

Thank you for your consideration.

_____ _____

Signature **Date**

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Statement of Patient Financial Responsibility

Patient Name: _____ **Date of Birth:** _____

FOSSITT THERAPY SERVICES INC. appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to FOSSITT THERAPY SERVICES INC., for providing services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to FOSSITT THERAPY SERVICES INC., the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient/Guarantor Signature _____ **Date** _____

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature _____ **Date** _____

Self-Pay

I do not have health insurance and will be responsible for services rendered here at FOSSITT THERAPY SERVICES INC. I agree to pay FOSSITT THERAPY SERVICES INC., the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature _____ **Date** _____

Motor Vehicle Insurance (PIP)

I request my claims be submitted to my motor vehicle carrier. In the event my PIP is exhausted or denied, my primary insurance carrier will be subsequently billed. I understand I will be responsible for bills incurred by me in the event my PIP or primary insurance benefit exhausts or denies.

Patient/Guarantor Signature _____ **Date** _____