SPINE AND SPORT BIOMECHANICAL REHABILITATION CENTER
MEDICARE PERSONAL PATIENT INFORMATION

Name: (F)_____(M.I.)_____(L)_____

Address_____

City: _____State: _____ Zip: _____

Birth Date: _____ Age: _____

Social Security Number: _____-_____-_____

Emergency Contact: _____

Emergency Contact Phone Number: (_____)_____

Relationship: _____

Primary Care Physician: _____

****Please indicate which phone number you prefer to be reached.**

Home Phone: (_____)_____

Cell Phone: (_____)_____

Email Address: _____

Occupation: _____ □Retired

Current Employer: _____

Who is responsible for payment of services at Spine & Sport?

Name: _____ Relationship to Patient: _____

Address: _____

Who can we thank for referring you to our practice? (Check all that apply)

□ Doctor: _____ □ Friend/Relative: _____

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information: Your Protected Health Information will be used by Spine & Sport Physical Therapy or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. Notice of Privacy Practices: You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have acknowledge receipt of the Notice of Patient Privacy Policy. Requesting a Restriction on the Use or Disclosure of Your Information: You may request a restriction on the use or disclosure of your Protected Health Information. This office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards. Notice of Treatment in Open or Common Areas: Please note that some of your treatment may be performed in an 'open' area. Private areas are always available to discuss your health information upon request.

I, hereby consent to have Spine & Sport, communicate with me by email or phone messages, regarding various aspects of my health care, which may include, but shall not be limited to, test results, appointments, and billing. I understand that email and phone messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that my medical care might be intercepted and read by a third party. I give my permission to leave both appointment reminders and my private health information by
Phone: □ YES □ NO **Email**: □ YES □ NO

Revocation of Consent: You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient Signature: _____ **Date:** _____

IMPORTANT INFORMATION REGARDING YOUR HEALTH INSURANCE

As the patient you are ultimately responsible for knowing your coverage before services are rendered. Any claims or procedures that are disputed, denied, or above your insurance's determination of reasonable and customary amounts will become your responsibility. *We do not offer any form of payment plans*. Please note that it may take 30(+) days for claims to be processed through your insurance. For the period January 1 through December 31 the cap for therapy is **$2,150** for physical and speech therapy combined. You and/or your secondary insurance are responsible for the balance that Medicare does not pay, up to the allowed amounts.

Initial next to the insurance coverage you have.

_____ **Medicare Part B with *no* Supplemental Insurance:** You are responsible for your deductible and the 20% that Medicare will not cover, which is approximately $10 - $20 per visit.

_____ **Medicare Part B with a Supplemental Insurance:** You are responsible for your deductible, and any amounts that Medicare and your secondary insurance do not cover. You will not pay at the time of service.

_____ **Blue Care Network Advantage HMO:** We do not participate, and cannot bill your insurance. You are responsible for payment in full at time of service.

_____ **Blue Cross Blue Shield Advantage Plus Blue:** You are responsible for your deductible, and any amounts that Medicare and your secondary insurance do not cover. You will not pay at the time of service.

_____ **Priority Health Medicare Advantage: (PPO & HMO-POS):** We are out of network with your insurance. You are responsible for your out-of-network deductible, and any services that are not covered by your insurance. You will not pay at the time of service.

_____ **Priority Health (HMO):** We do not participate and will not bill your insurance. You are responsible for payment in full at time of service.

_____ **All Other Medicare Advantage Plans:** We do not participate with these plans, however we will bill them for you. You are responsible for you're out of network deductible and co-insurance. You will not pay at the time of service.

_____ **Auto Insurance:** Auto Insurance will be your primary coverage; payment is not due at the time of service. *If your claim goes to litigation the balance remaining on your account will be due 90 days from last date of service.*

PLEASE LET OUR OFFICE KNOW IF YOU WOULD LIKE A WRITTEN COPY OF OUR GOOD FAITH & DISCLOSURE ESTIMATE.

By signing this form, I understand and agree that, regardless of my insurance status, I am financially responsible for the balance of my account for any and all professional services/supplies rendered. I understand that failure to pay my balance may result in additional fees and interest rates. **All bills unpaid after 90 days will be sent to collection**.

Please Read the Following:

- I assign directly to Spine and Sport all medical benefits, if any, otherwise payable to me for services rendered.
- Please give 24 hours' notice cancelation in order to avoid being charged for the appointment. There will be a $40 no-show fee that will be applied to your account if we do not receive proper cancelation notice.
- I have read all the information and have completed the above questions to the best of my knowledge. I will notify Spine and Sport of any changes in my personal and /or health information.

Patient Signature: _____ **Date**: _____