SPINE AND SPORT BIOMECHANICAL REHABILITATION CENTER
RE-EVALUATION PERSONAL PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State:_____ Zip:_____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Email Address: _____

Primary Care Physician: _____

Emergency Contact: _____ Phone: (_____)_____ Relationship: _____

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.

IMPORTANT INFORMATION REGARDING YOUR HEALTH INSURANCE

Please initial next to the insurance coverage you have: 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, additionally it may take 30(+) days for your insurance provider to process claims. *We do not offer any form of payment plans*.

_____ **Blue Cross Blue Shield / Priority Health / All other Plans**: You are responsible for payment in full at the time of service, by cash or check only. You will receive reimbursement from your insurance provider only once you have meet your out-of-network deductible. Any payments sent to Spine & Sport from your insurance will be reimbursed once therapy is complete and all claims have been processed.

_____ **HMO / EPO Plans:** We do not participate with these plans, claims cannot be billed to your insurance provider. You are responsible for payment in full at the time of service, by cash or check only.

_____ **Workman's Compensation:** Please make sure you have authorization from your employer regarding your claim. *If your claim goes to litigation the balance remaining on your account will be due 90 days from last date of service.*

_____ **Auto Insurance:** If your health insurance is *primary* to your Auto please call your Auto Insurance provider to verify if you have out of network coverage. If you do not have out of network coverage your Auto Insurance will not pay. *If your claim goes to litigation the balance remaining on your account will be due 90 days from last date of service.*

***HSA / FSA / HRA Accounts**: let our office know if you would like to receive reimbursement from your plan and we would be happy to provide you with proper forms. Additionally, you may pay using a check from these accounts, but we do not take payment from a card.

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

Please note there is a onetime **$35 yearly billing fee** for Spine & Sport to file claims to insurance (this does not apply for Auto/Work Comp claims). If you are unsure if you want Spine & Sport to file claims, we suggest you call your insurance provider and ask for your out-of-network deductible. If you would like to file your own claims Spine & Sport will provide you with any necessary billing records.

Would you like Spine & Sport to file claims for you: □YES □ NO

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**: _____