Office Use Only/Initials | Centennial | Cimarron | Sunset

Reason for Treatment:	Is your visit due to an injury?		Office Use Only: Health Insurance Verification
	No / Yes	If Yes:	
		Date of Injury:	INSURANCE APPROVED
		Date of Surgery:	INSURANCE DENIED
			Patient declined to provide insurance card,

PATIENT INFORMATION

Name:	*First* *Last*	**Birthdate**	
Address:	*Street*	**Age:**	
	City *State* *Zip*	**SSN:**	
Phone:	**Email:**	**Sex:**	

If the patient is a minor, what is the Parent(s)/Legal Guardian Name(s): ______

(check one)

Attorney Referral	*Attorney Name* ______	*Phone* ______
Physician Referral	*Physician Name* ______	*Phone* ______
Self Referral	***How did you hear about or choose us:*** ______	

(example: friend, provider search, Google, Yelp, Facebook, drove by, location)

Emergency Contact		
Name	**Relationship**	**Phone**

INSURANCE INFORMATION

Even if you are evaluating as a "personal injury/lien" patient, we will ask for your health insurance information. This is to protect you from having to pay out of pocket for your physcial therapy treatment, if you do not win your legal case. YOU WILL BE BILLED FOR SERVICES.

Primary Insurance: ______ **Member #:** ______ **Secondary Insurance:** ______ **Member #:** ______

Insured Name:	**Relationship to Patient:**	**Insured Name:**	**Relationship to Patient:**
Group #:	self	**Group #:**	self
DOB:	spouse	**DOB:**	spouse
SSN:	child	**SSN:**	child
	(check one)		*(check one)*

Patient Insurance Information and Responsibilities

Primary Insurance Benefits:		**Used**	**Secondary Ins. Benefits:**		**Used**	**Attorney Approved Visits / Amount:**		**Other Notes:**
Copay	$	$	Copay	$	$	Visit Total		
Deductible			Deductible					
Coinsurance	%	%	Coinsurance	%	%	Dollar Total	$	

I agree to pay ALL incurred charges, including copays, deductibles, coinsurance and balance billing charges not paid by the insurance carrier OR ATTORNEY. In "self pay" situations, I will be billed directly. (SPT Staff will complete this section above. Patient needs to review for accuracy and sign below.)

Patient Signature: Accuracy of Personal Information and Insurance Responsibilities

Print: ______

Signature: ______ ***Date:*** ______

PHYSICIAN INFORMATION

Referring Physician:	
Address	
Phone	

If different:

Primary Physician:	
Address	
Phone	

Have you had any therapy this year?

YES	No	
		Physical Therapy
		Occupational Therapy
		Speech Therapy
		Home Health Therapy

If **YES** where, and why:

If the patient is 3 years old or under, has the patient been seen for physical therapy at ANY other facility this year, including NEVADA EARLY INTERVENTION?

☐ Yes ☐ No

Is there anything else we need to know about the treatment you have had in the last 12 months?

CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of treatment, various activities associated with payment and health care operations. Our Notice of Privacy Practices provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our Notice of Privacy Practices, we reserve the right to change our privacy practices. If we should do so, we will issue a revised notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer: Allison Hollis at (702) 368-6778.

You have the right to revoke your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You You are entitled to a copy of this Consent Form after you have signed it.

Patient Signature: Statement of Other Treatment & Consent for Use & Disclosure of Health Information

Print: ______________________

Signature: ______________________ ***Date:*** ______________

Equipment Use Agreement

I understand that as a part of treatment, I have access to excercise equipment and will, at times, use this equipment, at times unsupervised. I will not hold Edwin Suarez Physical Therapy responsible for any injury and/or fall sustained as a result of using the equipment. I will also not try to adjust the equipment during treatment, as it may cause injury. Our staff is on hand to support and assist you.

Print:

Signature:

Date:

MEDICARE: Advanced Beneficiary Notice (if applicable)

Medicare ID #:

If you have Medicare Benefits, please read the following information regarding outpatient Physical Therapy benefits.

- Additional Form Needed / Advance Notice of Non-Coverage (SPT will pre-fill this for you)
- This office is a participating provider of Medicare.
- Outpatient Physical Therapy benefits are limited to $1,900.00 per year. Medicare will allow approximately 18 visits per plan year.
- Our office will not be able to treat a patient past the benefit limit, except on a CASH pay basis.

We know Medicare benefits can be difficult to understand, so we will make every effort to assist you. If you have further questions, please ask one of our staff to assist, or contact your Medicare representative.

Print:

Signature:

Date:

At your request, this form can be sent to your doctor to obtain your records

Date Sent:
Sent By:

Patient Consent to Release Medical Records

Patient Name: ______________________ DOB: __________
If a minor, Parent(s)/Legal Guardian Name(s): ______________________ Last 4 digits of SSN XXX-XX-______
Address ______________________ City ______ State ______ Zip ______
Phone: ______________________

Release from: Physician: ______________________ Phone: ______________________
Address: ______________________ Fax: ______________________
Address: ______________________

Please release my medical records to the location indicated below:

______ Suarez Physical Therapy
3620 E Sunset Rd. Suite 100
Las Vegas   NV 89120

______ Suarez Physical Therapy
6930 S. Cimarron Dr. Suite 160
Las Vegas NV 89113

______ Suarez Physical Therapy
6200 N Durango Dr. #120, Bldg 12
Las Vegas NV 89149

Information requested to be released :

- [ ] Radiology Reports (X-Rays, MRI's, CT Scan, etc)
- [ ] Operative / Surgery Reports
- [ ] Progress Notes
- [ ] Evaluation / Progress Notes
- [ ] Entire Medical Record
- [ ] Other : ______________________

For the purpose of :

- [ ] Treatment
- [ ] Billing / Payment
- [ ] Worker's Compensation
- [ ] Personal Records
- [ ] Other : ______________________

Patient Signature: Consent to Release Medical Records

Print: ______________________
Signature: ______________________ *Date:* ______________________

* This consent is specifically for information created from the services provided before the date of patient's signature.
* Information related to services AFTER the date of my signature will require an updated authorization.

If not previously revoked, this consent will term on this date: ____________________

OFFICE POLICIES

IMPORTANT: Attendance / Cancellations / No Call No Shows

I understand that because my health is a top priority, I will honor myself an my SPT team by being on time to all of my PT recovery appointments. I will be fully present with my SPT clinician(s) and follow their guidance and plan that they designed especially for my needs. During my sessions, I will focus my energy on healing myself, as I am taking full ownership over my own recovery experience.

Please initial each box:

[ ] If I am unable to attend any of my scheduled PT sessions, I will honor myself, my SPT team and my fellow SPT patients by calling **at least 24 hours in advance** to either reschedule or cancel my appointment.

[ ] I understand that if I have **more than TWO (2) missed appointments in a one-month period,** I will be responsible to pay a **$40 fee** and may be placed on a waiting list. I will not be charged if I reschedule an appointment within the same day at any of the three SPT locations.

[ ] I also understand that should I **"no call - no show"** (neglect to call my SPT team to let them know I am unable to make my appointment), I will be responsible to pay a **$50** fee.

[ ] If I am more than 15 minutes late for my appointment, my SPT team will do their best to accommodate me, but they may cancel my appointment and reschedule my session. Should I owe a fee, (**$40 for same day cancellations**) I will honor myself and my SPT team by paying in a timely fashion.
If you can reschedule your appointment within the same day, at any location, this $40 fee is not applied.

Print: ______________________________

Signature: ______________________________ ***Date:*** ______________

SPT Team Member

Print: ______________________________

Signature: ______________________________ ***Date:*** ______________

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 June 17, 2003 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 at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may 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 In 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 disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of 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 inmates or patients 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 may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (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 photocopies 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 to locate and copy your health information . If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. 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 for 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 before June 17, 2003. 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.

Restriction: 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 an 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 payments 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 received this Notice on our Web site 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 access to your health information or in response to a request you made to amend or restrict the use or disclosure of 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 Officer: Allison Hollis
Telephone: 702-368-6778 Fax: 702-368-6775
E-mail: allison@edwinsuarezpt.com
Address: 3620 E. Sunset Rd. #100, Las Vegas, NV 89120

Patient Signature: Acknowledgment of Privacy Practices

Print: ______________________________

Signature: ______________________________ ***Date:*** ____________

Suarez Physical Therapy **Suarez Physical Therapy** **Suarez Physical Therapy**

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Las Vegas   NV 89120

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Las Vegas NV 89113

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Las Vegas NV 89149