BODY BALANCE LAKEWAY

Medical History

Check YES or NO

Have you or any immediate family member ever been told you have ..... Self ..... Family

	Self		Family	
Cancer?	☐ Yes	☐ No	☐ Yes	☐ No
Diabetes?	☐ Yes	☐ No	☐ Yes	☐ No
High blood pressure?	☐ Yes	☐ No	☐ Yes	☐ No
Heart disease?	☐ Yes	☐ No	☐ Yes	☐ No
Angina/chest pain?	☐ Yes	☐ No	☐ Yes	☐ No
Stroke?	☐ Yes	☐ No	☐ Yes	☐ No
Osteoporosis?	☐ Yes	☐ No	☐ Yes	☐ No
Rheumatoid Arthritis?	☐ Yes	☐ No	☐ Yes	☐ No
Head/Neck Trauma?	☐ Yes	☐ No	☐ Yes	☐ No

In the past 3 months have you had or do you experience:

A change in your health?	☐ Yes	☐ No
Nausea/Vomiting?	☐ Yes	☐ No
Fever/chills/sweats?	☐ Yes	☐ No
Unexplained weight loss?	☐ Yes	☐ No
Numbness or tingling?	☐ Yes	☐ No
Changes in appetite?	☐ Yes	☐ No
Difficulty swallowing?	☐ Yes	☐ No
Changes in bowel or bladder function?	☐ Yes	☐ No
Shortness of breath?	☐ Yes	☐ No
Dizziness?	☐ Yes	☐ No
Upper respiratory infection?	☐ Yes	☐ No
Urinary tract infection?	☐ Yes	☐ No

General Information

Emergency Contact:_____

Relationship: _____

PH: _____

Who should we thank for this referral?

_____

What is/was your occupation?

_____

Current Employer :_____

PH:_____

Check YES or NO

Do you have a history of:

Allergies/Asthma?	☐ Yes	☐ No
Headaches?	☐ Yes	☐ No
Bronchitis?	☐ Yes	☐ No
Kidney Disease?	☐ Yes	☐ No
Rheumatic Fever?	☐ Yes	☐ No
Ulcers?	☐ Yes	☐ No
Sexually Transmitted Disease	☐ Yes	☐ No
Seizures?	☐ Yes	☐ No

Are you currently:

Pregnant?	☐ Yes	☐ No
Under Stress	☐ Yes	☐ No

Are your symptoms: (check one)

☐ Getting Worse ☐ The Same ☐ Improving

How are you able to sleep at night? (check one)

☐ Fine ☐ Moderate Difficulty ☐ Only with Medication

Check all that apply ……

Do you have a problem with …(check all that apply)

☐ Hearing ☐ Vision

☐ Speech ☐ Communication

Do you or have you in the past smoked tobacco?

☐ **YES** ☐ **NO**

If yes, _____Packs X _____ Years

Last tobacco use _____

Do you drink alcoholic beverages? ☐ **YES** ☐ **NO**

If yes, how many drinks do you routinely have per week? _____ / week

Date of last physical examination _____

List medications currently using: (or provide separate list)_____

_____

_____

BODY BALANCE LAKEWAY

TREATMENT AGREEMENTS

CONSENT FOR CARE AND TREATMENT: I, the undersigned, hereby consent to medical care and treatment as deemed necessary and proper by the medical staff of Body Balance Lakeway. If patient is a minor under the age of 18, a parent or legal guardian must sign this agreement. I agree and give my consent for Physical Therapy Services or Consult/Wellness to be provided by Body Balance Lakeway.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize insurance payment benefits to be paid directly to Body Balance Lakeway. I understand that insurance may not pay for all the services I receive and that I am responsible to pay for services or materials provided to me that are not paid by the insurance.

RELEASE OF INFORMATION: I authorize Body Balance Lakeway to release any information acquired in the course of my treatment to any person or entity which is or may be liable for all or any portion of the charges. A photocopy of this form shall be deemed as valid as the original.

CANCELLATION POLICY: Specific time is reserved for you when you schedule an appointment. If you cannot keep your scheduled appointment, please give us at least 24 hours notice so that we may reschedule your appointment and offer the reserved time to another patient. There will be a charge of $100 for NO SHOW appointments or cancellations with less than 24-hour notification. I understand that I will be personally responsible for any cancellation fees. Insurance companies do not reimburse for missed visits.

FINANCIAL POLICY: I have read the Financial Policy for Body Balance Lakeway and accept that I am ultimately financially responsible for all charges regardless of the outcome from insurance companies, third-party payers, or any other payers.

NOTICE OF PRIVACY POLICIES: I have read the Notice of Health Information and Privacy Policies.

I have read and fully understand all of the above information and hereby agree to comply as outlined above.

_____ Date: _____

Patient or Guardian Signature

BODY BALANCE LAKEWAY

OUR FINANCIAL POLICY

Thank you for choosing Body Balance Lakeway as your healthcare provider. We are committed to your treatment being successful and experience being positive. The following is out Financial Policy which we require that you read and sign prior to initiating your treatment. Please feel free to ask for a paper copy if you wish to bring one home with you.

Patient Responsibility for Insurance Verification

We strongly encourage you to call your insurance carrier to obtain your outpatient physical therapy benefits. You need to accurately verify and understand your policy's deductible, co-payment, coinsurance, visit limitations, and any pre-authorization requirements. As a courtesy, we will also verify your coverage, but we will not guarantee the accuracy of the information received. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Therefore, you are ultimately responsible for knowledge of your insurance benefits and for the full payment of your bill.

Regarding Insurance

We bill insurance companies as a courtesy to our patients. However, the balance is your responsibility whether your insurance company pays or not. In order for us to bill your insurance company, our patients must provide us with the following documents:

a. A current doctor prescription ordering physical therapy stating the diagnosis, frequency and duration; updated as necessary unless not required by your insurance company.
b. A copy of your insurance card.

**Please note that in Texas, we are able to perform an Evaluation without a doctor referral (prescription). But treatments thereafter require a prescription whether billing your insurance or not.

Our office will require payment in full for treatment rendered at the time of service if these documents are not provided. If your insurance company fails to reimburse us within 45 days, you will be responsible for the entire unpaid balance. It is YOUR responsibility to follow up with your insurance company regarding the status of your claim.

If we are a participating provider for your insurance plan, you might be required to pay a co-payment or coinsurance for services rendered. This can be a fixed dollar amount per visit (co-payment) or a percentage of the contracted rate (coinsurance). Since we may not be able to tell the exact amount of coinsurance payments ahead of time, we may estimate that amount and collect it each visit. Once payment is received from the insurance company, we will bill you for any amount not covered in the estimation or issue a refund check to you if over-payment is determined. We expect payment within 20 days of the date of the statement. A finance

charge of 1.5% will be assessed per month on all delinquent accounts. In the event that a check is returned for insufficient funds, a $25 charge will be applied to your account in addition to the unpaid balance.

Payment

1. Co-payments or coinsurance payments are due at each visit.
2. If you do not have insurance, full payment is due at the time of service.
3. We accept cash and checks. Credit card payments may also be accepted. Please inquire first.

Collections

We will work with you to avoid sending your account to collections. In the event of default on your account, and we are unable to reach a workable payment plan, your account will be turned over to a collection agency. You will be responsible for the unpaid balance and any charges associated with the cost of collection, including reasonable attorney fees, court costs, and finance charges.

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

Your signature is required on our separate “Treatment Agreements” page.

BODY BALANCE LAKEWAY

Notice of Privacy Policies

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

Body Balance Lakeway is committed to treating and using protected health information about you responsibly. I am required by federal and state law to maintain the privacy of your protected health information. This Notice of Health Information Practices describes the personal information I collect, and how and when I use or disclose that information. It also describes your rights as they relate to your protected health information (PHI). This Notice is effective April 1st, 2012 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you receive treatment form Body Balance Lakeway, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communication among the many health professionals who contribute to your .
- Legal document describing the care you
- Means by which you or a third-party payer can verify that services billed were actually provided.
- A tool in educating health professionals.
- A source of information for public health officials charged with improving the health of this state and the nation.
- A source of data for planning and marketing.
- A tool with which I can assess and continually work to improve the work I render and the outcomes I achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, where, when, and why others may access your information, and make more informed decisions when authorizing disclosures to others.

Your Health Information Rights

Although your health record is the physical property of Body Balance Lakeway, the information belongs to you.
You have the right to:
* Obtain a paper copy of this notice of information practices on request
* Inspect and receive a copy of your health record as provided for in 45 CFR 164.524
* Amend your health record as provided in 45 CFR 164.528
* Obtain a accounting of disclosures of your health information other than for treatment, payment, and healthcare operations as provided in 45 CFR 164.528
* Request communications of your healthcare information by alternative means or at alternative locations
* Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
*Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Body Balance Lakeway is required to:

- Maintain the privacy of your health information.
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will either mail or e-mail a revised notice to the addresses you've supplied us.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

Uses and Disclosures of Protected Health Information

We may use and disclose PHI about you for treatment, payment, and healthcare operations. Following are the types of uses and disclosures that I am permitted to make.

We will use and disclose health information for treatment.

For example: Information obtained by a physical therapist or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. We will document in your record your plan of care, treatment and interventions, observations, symptoms, tests and measurements, and your response to treatment.

We will also provide your physician, case manager, or subsequent healthcare provider with copies of various reports that should assist him/her in your treatment and care.

We will use and disclose your health information for payment.

For example: A bill may be sent to you or a third-party payer. We may use and disclose your PHI to submit bills to you or a third-party payer for healthcare services provided to you. We may disclose your PHI to another health plan, to a healthcare provider, or other entity subject to the Federal privacy rules for their payment purposes. Payment activities may include processing claims, determining eligibility or coverage for benefits, reviewing services for medical necessity, and performing utilization review of your account.

We will use and disclose health information for regular healthcare operations.

For example: Healthcare operations include the business functions conducted by a healthcare provider. Members of the healthcare staff may use information in your health record to perform transcription duties, as well as assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide. These activities may include providing customer services, transcription duties, responding to complaints, conducting review of accounts and other quality assessments and improvement activities.

Business associates: There are some services provided through contacts with business associates with whom we have written agreements containing terms to protect the privacy of your PHI. When these services are contracted, we may disclose your health information to my business associates so they can perform the job we have asked them to do, which may include

billing you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

- **Notification:** We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. We may leave a message on your answering machine or on voicemail as a means of communication. We may mail you a postcard or written notice as a means of communication. We may e-mail you, your healthcare provider, or case manager as a means of communication.

- **Communication with Family:** health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend, or any other person you identify health information relevant to that person's involvement in your care or payment related to your care.

- **Research:** We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

- **Workers Compensation:** We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law. This may include communication either in writing, e-mail, or by telephone with a case manager in charge of your case.

- **Public Health:** As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

- **Law Enforcement:** We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

- **On Your Authorization:** You may give us written authorization to use your PHI or to disclose it to another person and for the purpose you designate. If you give us an authorization, you may withdraw it in writing at any time. Your withdrawal will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give me a written authorization, we cannot use or disclose your PHI for any reason except those described in this notice.

For More Information or to Report a Problem

If you have any questions and would like additional information, you may contact Jille Dorler, PT or Paul Hendricks, PT at 512-261-8699.

If you believe your privacy rights have been violated, you can file a complaint with Jille Dorler, PT, Paul Hendricks, PT or with the Office for Civil Rights, US Department of Health and Human Resources. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office of Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S Department of Health and Human Services
200 Independence Ave S.W.
Room 509F, HHH Bldg.
Washington, DC 20201

Or, call Toll Free: 1-877-696-6775

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that I have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.