Sullivan Physical Therapy

NEW PATIENT INFORMATION

Patient Name*: _____

*As appearing on insurance card. If not on card, use first and last only

Social Security #: _____ **Preferred Name:**_____

Sex*: ____M ____F **Gender:** _____ **Birthdate:** _____

* As on file with insurance

Address:_____ **Primary phone:** _____

_____ **Secondary phone:**_____

City _____ **State**_____ **Zip** _____**Occupation:** _____

EMAIL COMMUNICATION CONSENT

By listing my email address below, I allow Sullivan Physical Therapy to communicate with me via email such as appointment reminders, my therapists contacting me about my care, newsletters, announcements, etc.

Email address:_____

EMERGENCY CONTACT INFORMATION

Name:_____ **Phone Number** _____ **Relation:**_____

INSURANCE INFORMATION

Primary Insurance company: _____

Are you the primary or a dependent on this policy? ____ **PRIMARY** ____**DEPENDENT**

If you are a dependent, is the policy owner your: ____**SPOUSE** ____**PARENT/STEP PARENT** ____**OTHER**

Policy Owner's Name:_____ **DOB:**_____

Policy Owner's Gender*: ____**M** ____**F**

*as on file with insurance

Secondary Insurance company: _____

Are you the primary or a dependent on this policy? ____ **PRIMARY** ____**DEPENDENT**

If you are a dependent, is the policy owner your: ____**SPOUSE** ____**PARENT/STEP PARENT** ____**OTHER**

Policy Owner's Name:_____ **DOB:**_____

Policy Owner's Gender*: ____**M** ____**F**

*as on file with insurance

Tertiary Insurance company: _____

Are you the primary or a dependent on this policy? ____ **PRIMARY** ____**DEPENDENT**

If you are a dependent, is the policy owner your: ____**SPOUSE** ____**PARENT/STEP PARENT** ____**OTHER**

Policy Owner's Name:_____ **DOB:**_____

Policy Owner's Gender*: ____**M** ____**F**

*as on file with insurance

Patient/Legal Guardian signature: _____ **Date:** _____

Sullivan Physical Therapy

Date of Birth: _____

Patient name: _____

CONSENT FOR CARE

I agree and give my consent for Sullivan Physical Therapy to provide physical therapy treatment that is considered necessary in treating the diagnosis assigned by the referring physician. I understand that it may be necessary, initially and periodically, for the physical therapist to perform an evaluation and treatment of the pelvic floor muscles inside the vaginal or rectal canals. I understand that these procedures will be fully explained before they are provided and that I have the right to refuse or stop treatment at any time. I also understand that I have the option to bring a family member or friend to these appointments.

Patient/Legal Guardian signature: _____ **Date:** _____

ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits to include all major medical benefits to which I am entitled, including Medicare, private insurance and third party payers to Sullivan Physical Therapy. A photocopy of this assignment is considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Patient/Legal Guardian signature: _____ **Date:** _____

CANCELLATION / NO SHOW POLICY

Sullivan Physical Therapy strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved appointment slots for each patient. Your timely and consistent attendance of the planned treatment regimen is paramount to your full recovery.

It is growing concern when you cancel your appointment at the last minute or fail to show up at all. This limits our ability to accommodate the scheduling needs of ALL of our patients. It is also a concern if you arrive late for your scheduled appointment time. Therefore, we ask your cooperation with the following policy…

If you are unable to keep your scheduled appointment, we respectfully request that you notify us no later than 24 hours before your appointment time. You may notify us by voicemail, or email at any time during the day. This will enable us to reschedule your appointment.

If you cancel your appointment with less than a 24 hour notice or do not show up at all, you will be billed a fee of $50.00 for each appointment missed.

If you arrive more than 35 minutes late for your scheduled appointment start time, you will be billed a fee of $50.00 and will be unable to receive treatment on that day.

If you have three (3) cancellations and/or no-shows for any reason you may be discharged from physical therapy. All cancellations and no-shows will be documented in your medical records and will be reported to your physician, insurance company and/or third party payer.

If you have not been seen by us in sixty (60) days and/or your prescription is expired you will be discharged from physical therapy. This will be reported to your physician, insurance company and/or third party payer.

Patient/Legal Guardian signature: _____ **Date:** _____

HIPAA - NOTICE OF PRIVACY POLICY (NPP)

I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP) and that I have read (or had the opportunity to read if I so choose). I understand the Notice of Privacy Policy (NPP) and agree to its terms.

Patient/Legal Guardian signature: _____ **Date:** _____

Sullivan Physical Therapy

Date of Birth: _____

Patient name: _____

REFERRAL INFORMATION

Referring Provider: _____

Referring Provider's Phone Number: _____

Primary Symptoms/ Diagnosis: _____

Prior surgeries related to this issue with approximate date(s): _____

MEDICATION*

MEDICAL HISTORY

For the issue listed above **, please check which of the following services you have received:**

___Family physician	___Oncologist	___Chiropractor	___EMG/NCV (muscle/nerve)
___OBGYN/ Midwife	___Orthopedist	___MRI	___Emergency Room
___Urologist	___Physical Therapy	___Myelogram (x-ray w/dye)	___CT Scan
___Neurologist	___Massage Therapy	___X-Ray	___Bladder Test

Do you now have or have you ever had any of the following? Please check all that apply:

___Allergies	___Cancer	___Heart Disease	___Pins/Metal Implants
___Anemia	___Currently Pregnant	___High Blood Pressure	___Sexual Abuse/Trauma
___Arthritis	___Trying to Become Pregnant	___Infectious Disease	___Stroke/TIA
___Asthma	___Diabetes	___Osteoporosis/penia	___Weight/Energy Loss
___Blood Clot/Emboli	___Epilepsy/Seizures	___Pacemaker	___Other: _____
___Multiple UTI's	___Recurrent UTI-like symptoms	___Multiple Vaginal Infections	___Other: _____

ADDITIONAL INFORMATION

Please list any additional information that would assist us in your care: _____

_____

Are you aware of what your diagnosis is? ____**YES** ____**NO**

What are your expectations / goals of physical therapy? (Please list at least one.) _____

_____

_____

Patient/Legal Guardian signature: _____ **Date:** _____

Sullivan Physical Therapy

12411 Hymeadow Drive, Building 3, Suite 3B
Austin, Texas 78750
Phone: 512-335-9300 Fax: 512-335-9301
Email: sullivanphysicaltherapy@yahoo.com
Website: www.sullivanphysicaltherapy.com

HIPAA - NOTICE OF PRIVACY POLICY (NPP)
EFFECTIVE DATE: April 28, 2015

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

Purpose of this Notice: Sullivan Physical Therapy is required by law to maintain the privacy of your Protected Health Information **(PHI)**. We are also required to provide you with a copy of this NPP, which contains our privacy practices and outlines how Sullivan Physical Therapy is permitted to use and disclose PHI about you. Sullivan Physical Therapy is also required to abide by the terms of the version of this notice currently in effect. In most situations we may use this information as described in this notice without your permission, but there are some situations where we may use it only after we obtain our patients written authorization, if we are required by law to do so.

Use and Disclosure of PHI: Sullivan Physical Therapy may use or disclose your PHI for treatment, payment or health care operations. For your convenience, we have provided the following examples of such potential uses or disclosures:

- ***For Treatment***. Your PHI may be used to provide you with medical treatment for services. For example, information obtained from your referring physician, nurse or their administrative staff will be recorded information in your record that is related to your treatment. This information is necessary for us to determine what treatment you should receive.
    - Any progress notes, plans of care and prescription requests may be released solely to your referring physician, nurse or their administrative staff via facsimile or email for the purpose of updating them on your care and determining your continued therapy needs.
- ***For Payment:*** This includes any activities we must undertake in order to get reimbursed for the services provided to you, including such things as organizing PHI and submitting bills to insurance companies (either directly or through a third party), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review and collection of outstanding accounts.
    - Sullivan Physical Therapy will not use or disclose more information for payment purposes than is necessary. This is known as using only the minimum necessary amount to accomplish the purpose of use or disclosure. We are accountable to the secretary of Health and Human Services to safeguard (keep secure) and protect (keep private) our patients' information.
- ***Health Care Operations.*** Your PHI may be used or disclosed as part of our internal health care operations. Such health care operations may include, among other things, quality of care audits of our staff and affiliates, conducting training programs, accreditation, certification, licensing or credentialing activities, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes and certain marketing activities.
- ***Notification in the Case of a Breach:*** Sullivan Physical Therapy is required by law to notify our patients in case of a breach of their unsecured PHI when it has been or is reasonably believed to have been accessed, acquired or disclosed as a result of a breach.
- ***For Marketing Communications:*** We may use or disclose your health information to identify health-related services and products that may be beneficial to your health and we may contact you about these services and products. All marketing requires written authorization from you, except face-to face and general health reminders and governmental notices.
- ***Use and Disclosure of PHI Without Your Authorization:*** Sullivan Physical Therapy is permitted to use PHI *without* written authorization or opportunity to object in certain situations, including:
    - For Sullivan Physical Therapy's use in obtaining payment for services provided or in other health care operations;
    - To another health care provider or entity for the payment activities of the provider or entity that receives the information (such as your referring physician or insurance company);
    - To another health care provider (such as your referring physician) for the health care operations activities of the entity that receives the information as long as the entity receiving the information has or has had a relationship with our patients and the PHI pertains to that relationship;
    - For health care fraud and abuse detection or for activities related to compliance with the law;
      To a family member, other relative or close personal friend or other individual involved in our patients care if we obtain verbal agreement to do so or if we give our patients an opportunity to object to such a disclosure and you

do not raise an objection. We may also disclose health information to family, relatives or friends if we infer from the circumstances that there is no objection. For example, we may assume our patients' agree to our disclosure of personal health information to their spouse when their spouse has called us for them. In situations where our patients are not capable of objecting (because the patients are not present or due to incapacity or medical emergency), we may, in our professional judgment, determine that a disclosure to our patient's family member, relative or friend is in the best interest. In that situation, we will disclose only health information relevant to that person's involvement in our patient care;
    - To a public health authority in certain situations (as required by law, as part of a public health investigation, to report child or adult abuse or neglect or domestic violence, to report adverse events such as product defects or to notify a person about exposure to a possible communicable disease) as required by law;
    - For health oversight activities including audits or government investigations, inspections, disciplinary proceedings and other administrative or judicial actions undertaken by the government (or their contractors) by law to oversee the health care system;
    - For judicial and administrative proceedings as required by a court or administrative order, or in some cases in response to a subpoena or other legal process;
    - For law enforcement activities in limited situations, such as when there is a warrant for the request or when the information is needed to locate a suspect or stop a crime;
    - For military, national defense and security and other special government functions;
    - To avert a serious threat to the health and safety of a person or the public at large;
    - For workers' compensation purposes and in compliance with workers' compensation laws;
- Any other use or disclosure of PHI, other than those listed above, will only be made with written authorization (the authorization must specifically identify the information we seek to use or disclose, as well as when and how we seek to use or disclose it). **Authorization may be revoked at any time, in writing, except to the extent that we have already used or disclosed medical information in reliance on that authorization.**

Your Individual Rights:

- ***Access, Copy and Inspect PHI:*** You have the right to view your PHI at any time. You also have the right to copies at a charge determined by the current law.
- ***Alternate Communications:*** You have the right to request that we communicate with you about your PHI by alternative means or in alternative locations. We will accommodate any reasonable request if it specifies in writing the alternative means or location.
- ***Amendments to PHI:*** You have the right to request that we amend your PHI if it contains incorrect information. Such requests must be in writing and contain a detailed explanation for the requested amendment.
- ***The right to request an accounting of our use and disclosure of you PHI*****:** You may request an accounting from us of certain disclosures of your medical information that we have made in the last six years prior to the date of the request.
    - We are not required to give an accounting of information we have used or disclosed for purposes of treatment, payment or health care operations.
    - We also are <u>not required</u> to give an accounting of our uses of PHI for which we already have a written authorization for such use. To request an accounting of the medical information that we have used or disclosed that is not exempted from the accounting requirement, contact the Privacy Officer listed at the end of this Notice.
- ***The right to request that we restrict the uses and disclosures of an individual's PHI*****:** You have the right to request that we restrict how we use and disclose your medical information that we have for treatment, payment or health care operations or to restrict the information that is provided to family, friends and other individuals involved in your health care. We are under no obligation to agree to these requests for restrictions; however we will do so as long as it does not interfere with the uses and disclosures listed above. If any restricted information is needed to provide emergency treatment, then we may use the PHI or disclose the PHI to a health care provider to provide you with emergency treatment.
- You have a right to a restriction to disclosure of PHI to a health plan for payment if the patient has paid in full for the services and items provided in that visit.

Revisions to this Notice: We may revise our privacy practices and the terms of our NPP at any time as permitted or required by applicable law. We reserve the right to apply a change in our policies to previously received PHI effective immediately. Any material changes to the Notice will be promptly posted in our facilities and posted to our website. You have the right to request a copy of this NPP by paper, email or have it mailed to your address on file. Please contact us and a copy will be made available to you at no cost.

Your Legal Rights and Complaints: We support your right to protect the privacy of your medical 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 at www.hhs.gov/ocr or by calling 1-866-627-7748.

If you have any questions or if you wish to file a complaint or exercise any rights listed in this Notice, please contact: Privacy Officer by email to lauren@sullivanphysicaltherapy.com or by mail to Sullivan Physical Therapy,12411 Hymeadow Dr Bldg, 3 Ste 3B, Austin TX 78750.

Sullivan Physical Therapy

12411 Hymeadow Drive, Building 3, Suite 3B
Austin, Texas 78750
Phone: 512-335-9300 Fax: 512-335-9301
Email: sullivanphysicaltherapy@yahoo.com
Website: www.sullivanphysicaltherapy.com

DIRECTIONS TO OUR LOCATION

We are located in the Anderson Mill Medical Center on Hymeadow Drive (Hymeadow Drive is between Lake Creek Parkway and Anderson Mill Road on the southbound side of 183/Research Boulevard)

FROM 620 (COMING FROM ROUND ROCK)
Follow RM/RR 620 to Austin (you do not have to take the 45-Tollway, just follow signs for 620)*
Turn left onto Lake Creek Parkway (you'll pass a Wal-Mart shopping center on your right)
Turn left onto183S, getting in the right lane
Turn right onto Hymeadow (about 2/10 of a mile from Lake Creek Parkway…between the DPS office and the Summit Executive Centre)
Take the 5th entrance/driveway on your left (immediately after the Kangos Pediatrics sign)
Follow the parking lot to the right and Sullivan Physical Therapy will be on your left (our door faces Hymeadow Drive)

*If taking the 45-Tollway: follow 45W and take the "Lake Creek Parkway" exit (do not take the 183 exit, this will take you too far south), then follow above

FROM 620 (COMING FROM LAKEWAY)
Turn right onto183S, staying on the 183S access road
Go through the light at Lake Creek Parkway (you'll see Taco Bell on your right), getting in the right lane Turn right onto Hymeadow (about 2/10 of a mile from Lake Creek Parkway…between the DPS office and the Summit Executive Centre)
Take the 5th entrance/driveway on your left (immediately after the Kangos Pediatrics sign)
Follow the parking lot to the right and Sullivan Physical Therapy will be on your left (our door faces Hymeadow Drive)

FROM MOPAC or IH 35
Exit 183N
Follow 183N and exit at Lake Creek Parkway, stay in left lane
Loop around under 183 so you are on the 183S access road, getting in the right lane
Turn right onto Hymeadow (about 2/10 of a mile from Lake Creek Parkway…between the DPS office and the Summit Executive Center)
Take the 5th entrance/driveway on your left (immediately after the Kangos Pediatrics sign)
Follow the parking lot to the right and Sullivan Physical Therapy will be on your left (our door faces Hymeadow Drive)