Notice of Patient Information Practices

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

Imagine Physical Therapy, LLC is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Imagine Physical Therapy, LLC uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Imagine Physical Therapy, LLC may use your protected health information to contact you to provide appointment reminders or information about treatment alternatives or other health related benefits that could be of interest to you.

Imagine Physical Therapy, LLC may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Imagine Physical Therapy, LLC's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosure at any time.

Imagine Physical Therapy, LLC may change its policy at any time. When changes are made, a new Notice of Patient Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Patient Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Imagine Physical Therapy, LLC will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Imagine Physical Therapy, LLC may have violated your privacy rights or if you disagree with any decision we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Imagine Physical Therapy, LLC's health information practices or if you have a complaint, please contact John Mart, owner of Imagine Physical Therapy, LLC.

Mount Pleasant
3301 Stockdale Street
Mt Pleasant, SC 29466
Frontdesk@ImaginePT.com
(843)-375-5448

Daniel Island
295 Seven Farms Dr, Ste 200B
Daniel Island, SC 29492
DanielIsland@ImaginePT.com
(843)-377-8820

West Ashley
1964 Ashley River Rd, Ste C-1
Charleston, SC 29407
WestAshley@ImaginePT.com
(843)-576-4121

Imagine Physical Therapy
...immeasurably more than you could ask or imagine.

NEW PATIENT INFORMATION

Date: _____ / _____ / _____

Last Name_____ First name _____ MI _____ Preferred Name _____

Birth Date _____ / _____ / _____ Age _____ Sex: M F (*please circle*) Marital Status: S M W D P (*please circle*)

Address (mailing) _____ City _____ State _____ Zip _____

Address (physical) _____ City _____ State _____ Zip _____

Email Address _____ Social Security #: _____ / _____ / _____

Home Phone (_____) - _____ - _____ Cell (_____) - _____ - _____ Work (_____) - _____ - _____

Emergency Contact _____ Phone (_____) - _____ - _____ Relationship _____

Current Employer _____ Occupation _____

Were you injured on the job? ☐ Yes ☐ No Date of injury _____ / _____ / _____ Claim # _____
Name of Adjustor _____ Phone (_____) - _____ - _____
Name and address of Employer at time of Accident: _____

Were you injured in a car accident? ☐ Yes ☐ No Date of injury_____ / _____ / _____ State ____ Claim #_____
Name of Adjustor _____ Phone (_____) - _____ - _____
Name of Attorney _____ Phone (_____) - _____ - _____

Primary Insurance or Workers Comp	**Secondary Insurance**
Complete Blanks using INSURED'S information	*Complete Blanks using INSURED'S information*
Insurance Company _____	Insurance Company _____
Insured's ID#: _____	Insured's ID#: _____
Group# _____	Group# _____
Insured's Name _____	Insured's Name _____
Birth Date _____ / _____ / _____	Birth Date _____ / _____ / _____
Patient's relationship to insured _____	Patient's relationship to insured _____
Employer _____	Employer _____

Name of person responsible for bill _____ SS #: _____ / _____ / _____
Address of person responsible _____ City _____ St _____ Zip _____

I authorize the release of any medical or other information necessary to process insurance claims. I also authorize the payment of medical benefits directly to Imagine Physical Therapy, LLC for the services rendered. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered effective and valid as the original.

_____ _____ / _____ / _____
Signature Date
(*Person responsible for the bill and/or Legal Guardian if Patient is under the age of 18)*

FINANCIAL POLICY

Imagine Physical Therapy, LLC

Payment is expected at the time services are rendered; other arrangements must be made prior to treatment.

1. **COMMERCIAL/GROUP INSURANCE**: (BlueCross, Aetna, Cigna, etc): After verification of coverage with your insurance company/companies, we will file a claim as a courtesy to you. We reserve the right to release information for insurance purposes. If your deductible has not been met or cannot be verified**, WE WILL REQUIRE THE PAYMENT OF YOUR DEDUCTIBLE AMOUNT**. We then require that you pay the Co-pay/Coinsurance due by you, at the beginning of each visit. We will allow 45 days for your insurance company to pay assigned claims, after which time we will hold you, the patient, responsible for payment of your account.

2. **WORKERS' COMPENSATION**: We will verify your workers' compensation coverage with your employer or the company where you were employed at the time of your accident. After verification, we will file your claims for you. If your Workers' compensation is denied for any reason, YOU will be responsible for your bill. If we have to file your group insurance (because your Workers' Compensation was denied), any amount not paid by your group insurance will be YOUR responsibility. (Please give us your group health insurance so we can have a copy on file should your workers' compensation be denied) Missed appointments will be reported to your employer, case manager, physician, and documented in your clinical record. Missed appointments may lead to the disruption of your workers' compensation payments if you do not follow the directives of your physician for treatment.

3. **MEDICARE**: Coverage by Medicare will be limited for outpatient physical therapy (PT), speech-language pathology (SLP), and occupational therapy (OT) services received on January 1, 2013 through December 31, 2013. The limits are $1900.00 for PT and SLP combined and $1880 for OT. Medicare pays up to 80% of the limits after the deductible ($147) has been met. These limits do not apply to certain therapy approved by Medicare or to therapy you receive from hospital outpatient departments, unless you are a resident of and occupy a Medicare-certified bed in a skilled nursing facility. If you have any questions, please call 1-800-MEDICARE.
   You are responsible for the annual $147 deductible. Medicare will only pay for physical therapy after expenses exceed $140. Medicare will then pay 80% of the allowable charges. Therefore, YOU are responsible for the remaining 20%. If you have secondary insurance coverage and provide us with that information, we will bill your secondary insurance as a courtesy to you. If you do not have secondary insurance or your secondary insurance fails to pay for your services, YOU are responsible for the payment of the 20%. If Medicare denies charges because you have other insurance that is considered primary insurance, you will be responsible for all incurred charges. Please inform us of any other insurance coverage that you may have.

4. **AUTO ACCIDENT/ATTORNEY**: If you have been involved in an accident and have an attorney representing you, we prefer to bill your health insurance, to comply with the "timely submission of claims" provision of your policy. This will protect you in the event that your case is lost. However, if you decide to work solely through your attorney or liability insurance, you will be required to sign our Assignment of Benefits form. After signing this form, you waive your option for us to bill your primary insurance at a later date. If settlement is not reached with twelve (12) months of today's date, you will be billed for the balance in full.

5. **NO INSURANCE**: If you do not have insurance coverage, the charges incurred will be your responsibility. We are **MOST** concerned with your complete recovery. We are glad to work out a payment plan to insure that you get the maximum benefit from physical therapy.

6. **CANCELLATION/NO SHOW POLICY**: In order to receive the maximum benefit from your physical therapy, it is important to keep your scheduled appointments. We have dedicated an appointment time and paid staff members to be here for your scheduled appointment. Therefore, if you fail to attend your scheduled appointment, or do not call to cancel or reschedule your appointment within **24 hours** of your scheduled appointment time, you will be charged a **$30.00 Cancellation Fee**.
   If you cancel or fail to show for three (3) consecutive appointments, you may be discharged from therapy.

I have read the above policy and fully understand my responsibilities.

Patient/Guardian Signature _____ Date _____

3-2013-IPT-W

PATIENT AUTHORIZATION AND CONSENT

Patient Name: _____

I hereby consent to treatment.

I authorize Imagine Physical Therapy, LLC and/or its subsidiaries and affiliates to obtain medical records and/or professional information from my physician or other medical professionals as it relates to my treatment.

I have received Imagine Physical Therapy, LLC's Notice of Information Practices. I understand that Imagine Physical Therapy, LLC and its subsidiaries and affiliates may use or disclose my personal health information to my insurance company, rehab nurse, case manager, attorney, employer, school, relate healthcare provider, assignees and/or beneficiaries and all other relates persons as it relates to my treatment. I understand that I have the right to restrict how my personal health information is used and disclosed if I notify the practice in writing. I also understand that Imagine Physical Therapy, LLC will consider requests on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby authorize one or all of the designated parties below to request the release of and receive any protected health information regarding my treatment, payment, or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Name & Relationship _____
Name & Relationship _____
Name & Relationship _____
Name & Relationship _____

From time to time Imagine Physical Therapy, LLC may want to use protected health information, comments, and/or photographs in target marketing campaigns, fund raising, and research studies.

☐ I authorize Imagine Physical Therapy, LLC to use my protected health information, comments, and/or photographs as listed above.

☐ I do not authorize Imagine Physical Therapy, LLC to use my protected health information, comments, and/or photographs as listed above.

Payment Guarantee: I agree to pay Imagine Physical Therapy, LLC, its subsidiaries and/or affiliates for the services provided to me or the party named above. If any law, such as Workers' Compensation, or insurance contract prohibits payment for these services, I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Imagine Physical Therapy, LLC and/or its affiliates or subsidiaries.

_____ _____

Patient/Guardian Signature Date

BRIEF MEDICAL HISTORY

Patient Name: _____
Reason for Therapy: _____
Name of Referring Doctor: _____
How did injury occur? _____
Date of Injury: _____
Have you received therapy for this injury? ☐Yes ☐No If yes, when? _____
Type of treatment. Was it successful? _____
Have you received Home Healthcare Services within the past 30 days? _____
What aggravates your symptoms? _____
What relieves your symptoms? _____
Please rate your pain between 0 and 10 (***0*** *is no pain,* ***10*** *is likened to child birth or passing a kidney stone*)
At worse _____ Present _____ At best _____

Do you now, or have you in the past, had any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Diabetes	☐	☐	Current Infections	☐	☐	Previous Fractures	☐	☐
Arthritis	☐	☐	Heat/Cold Hypersensitivity	☐	☐	Osteoporosis	☐	☐
High Blood Pressure	☐	☐	Allergies	☐	☐	Depression	☐	☐
Heart Disease	☐	☐	Hernia	☐	☐	Anxiety	☐	☐
Heart Attack	☐	☐	Presently Pregnant	☐	☐	Substance Abuse	☐	☐
Pacemaker Implant	☐	☐	Seizures	☐	☐	Controlled Substance Abuse	☐	☐
Vascular Disease	☐	☐	Metal in Body	☐	☐	Tobacco Use	☐	☐
Headaches	☐	☐	Cancer/Tumor	☐	☐	Alcohol Use	☐	☐
Kidney Problems	☐	☐	Thyroid Problems	☐	☐	Previous Surgeries	☐	☐
Open Wounds	☐	☐	CVA/Stroke	☐	☐	Other	☐	☐

If you answered yes to any of the above, please explain and give approximate dates:

_____
_____
_____

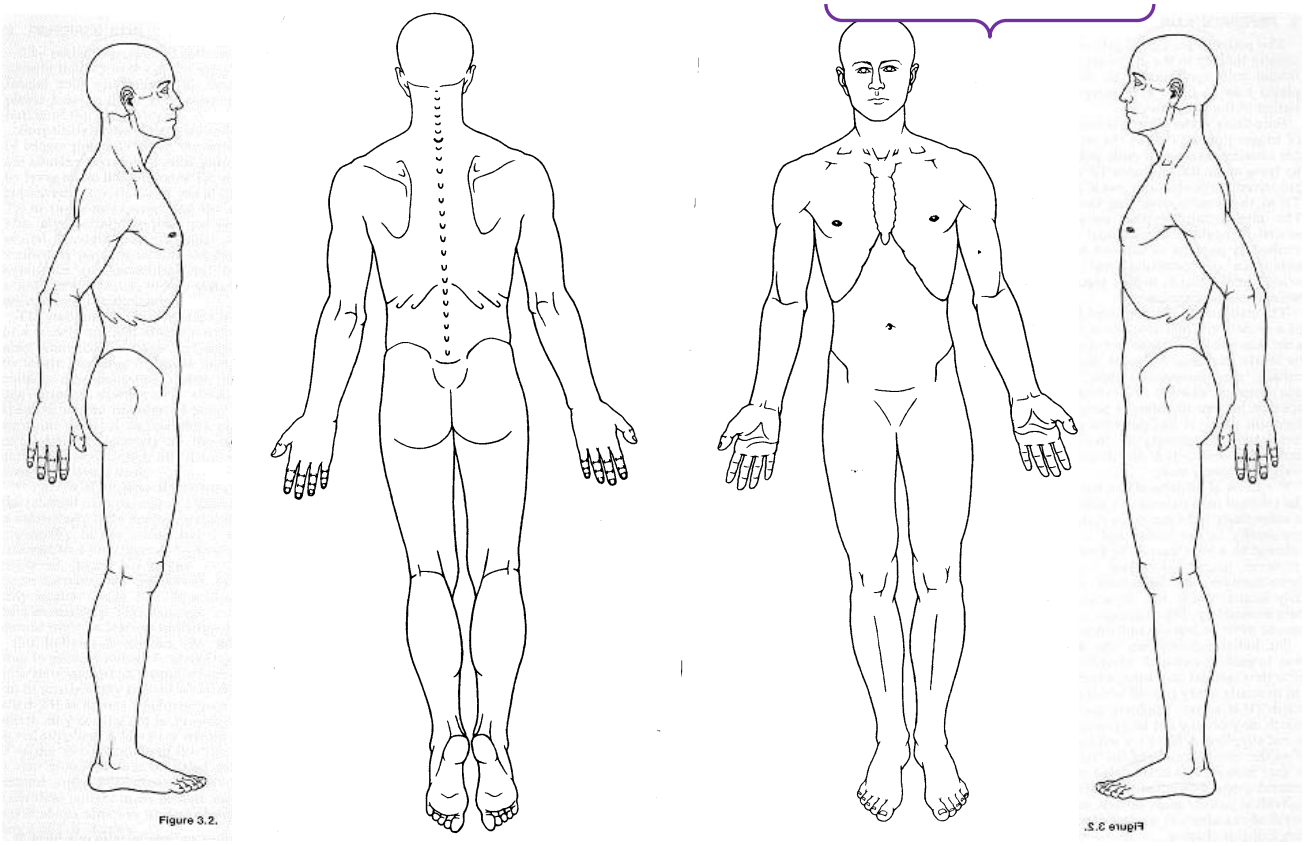
Please list all current medications
(prescriptions, over-the-counter, herbals,vitamins/minerals/dietary/nutritional supplements) and specify dosage:

_____
_____
_____
_____

The information above is correct to the best of my knowledge. If anything changes, I agree to notify Imagine Physical Therapy, LLC and update this form.

_____ _____
Patient/Guardian Signature Date

Pain Drawing



Relating to your present injury or condition

Indicate where your pain is located and what type of pain you feel at the present time.
Use the symbols below to describe your pain.

/ / / /	Stabbing
X X X	Burning
O O O	Pins and Needles
= = =	Numbness

Patient-Specific Activity Scoring Scheme

Name: _____

Date: _____

Please list at least 3 activities that are affected by your symptoms. Then rate how this activity is influenced by the symptoms.
0 = **no pain** with the activity, symptoms do not interfere with the activity.
10 = **extreme pain**, unable to perform the activity due to symptoms, must go to the emergency room.
Mark on the line, the degree of difficulty you have with the activity because of symptoms.

Activity	**Difficulty Level**
1. _____	_____ 0 1 2 3 4 5 6 7 8 9 10
2. _____	_____ 0 1 2 3 4 5 6 7 8 9 10
3. _____	_____ 0 1 2 3 4 5 6 7 8 9 10
4. _____	_____ 0 1 2 3 4 5 6 7 8 9 10
5. _____	_____ 0 1 2 3 4 5 6 7 8 9 10
6. _____	_____ 0 1 2 3 4 5 6 7 8 9 10