421 Chatham Square
Fredericksburg, VA 22405
540-373-3031

Checklist of items required for your first visit to OSPTA:

- ☐ Forms in this packet, completed
- ☐ Referral from your physician for physical therapy (prescription), if applicable
- ☐ Medication list, including drug name, dosage, and reason taken
- ☐ Co-payment if required
- ☐ Insurance authorization if required

Please have your completed forms with you for your initial visit, or your appointment may need to be rescheduled.

Please bring your insurance card(s) and, if applicable, your paper prescription for physical therapy from your physician's office, or we will not be able to begin treatment after your evaluation.

Bring results from any pertinent radiology and/or laboratory diagnostic tests (MRI, X-ray, CT scan, ultrasound, etc).

Workers' compensation cases: You must also have your employer's name and address, and the workers' compensation carrier's name and address, and your case manager contact information.

Please Note:
Your first therapy appointment will be lengthy (up to 2 hours) due to paperwork, insurance verification, history taking, examination and treatment. Most subsequent visits will be shorter in length depending upon the complexity of your condition. Therefore, it is important that you be on time for your appointment. If you are late by 10 minutes or more, we will need to reschedule your appointment.

Please do not bring children with you to your appointments. The reception area is unsupervised, the treatment rooms are small, and the gym area can be dangerous for small children. Thank you for understanding.

Please bring or wear loose fitting clothing. We can provide shorts or a medical gown if necessary.

OSPTA
ORTHOPEDIC & SPORTS PHYSICAL THERAPY ASSOCIATES

TODAY'S DATE _____/_____/_____

PATIENT NAME _____ BIRTHDATE _____/_____/_____
(First) (MI) (Last)

SEX: M or F MARITAL STATUS: S M W SSN _____ - _____ - _____ EMAIL: _____

MAILING ADDRESS _____
STREET ADDRESS CITY ZIP

HOME PHONE (___) _____ CELL (___) _____ WORK PHONE (___) _____

PATIENT'S EMPLOYER _____

EMPLOYER ADDRESS _____

SPOUSE'S NAME _____ CELL (___) _____ WORK PHONE (___) _____

DATE OF INJURY / PROBLEM _____ TYPE OF ACCIDENT _____

PRIMARY CARE PHYSICIAN _____ REFERRING PHYSICIAN _____

EMERGENCY CONTACT _____ CELL (___) _____

HOW DID YOU COME TO CHOOSE OSPTA FOR YOUR PHYSICAL THERAPY CARE?
____Physician Recommendation _____Family/Friend Recommendation ____Insurance Provider Recommendation
____Previous Patient of OSPTA _____Advertisement (where?): _____
Other: _____

RESPONSIBLE PARTY INFORMATION:

NAME _____ HOME (___) _____

ADDRESS _____ CELL (___) _____

EMPLOYER _____ WORK (____) _____

EMPLOYER'S ADDRESS _____

INSURANCE INFORMATION

PRIMARY INSURANCE CO. _____

POLICY # _____ GROUP / PLAN # _____

MAILING ADDRESS _____

SUBSCRIBER NAME _____ DATE OF BIRTH _____

SUBSCRIBER SSN _____ - _____ - _____ RELATIONSHIP TO PATIENT _____

SECONDARY/SUPPLEMENTAL INSURANCE CO _____

POLICY # _____ GROUP / PLAN # _____

MAILING ADDRESS _____

SUBSCRIBER NAME _____ DATE OF BIRTH _____

SUBSCRIBER SSN _____ - _____ - _____ RELATIONSHIP TO PATIENT _____

IF THIS IS A WORK-RELATED INJURY, PLEASE COMPLETE SECTION BELOW IN FULL:

EMPLOYER AT TIME OF ACCIDENT _____

EMPLOYER ADDRESS _____

SUPERVISOR OR PERSONNEL REP NAME _____

EMPLOYER PHONE (____) _____ INJURY DATE _____

TYPE OF INJURY _____ ARE YOU PRESENTLY WORKING? _____

HOW INJURY OCCURED _____

_____

IMPORTANT INSURANCE & BILLING INFORMATION

We are dedicated to your treatment and take pride in the quality care that we deliver. In order to avoid misunderstandings the following information is provided.

As a courtesy to you, we will file all insurance claims. Your insurance coverage is an agreement between you and your insurance company. We do not necessarily accept insurance company allowances as full payment for your account. Due to the volume of claims filed by our office we are unable to follow up on unpaid or unprocessed claims. After 60 days any unpaid insurance claims become your full responsibility. Since insurance policies vary greatly, it is your responsibility to contact your insurance company if you have questions regarding your policy.

Your co-payment is requested at the time of service. We accept cash, personal checks, Visa, MasterCard, Discover and American Express. A $25.00 fee will be collected for checks returned by the bank. If you are experiencing circumstances beyond your control, financial arrangements may be made with our billing office prior to your initial appointment. Balances carried 90 days or greater are subject to a $7.50 per month handling fee charge. Payments made to these balances will be applied to the handling fee(s) first. Collection fees and/or court costs will be the patient's or patient's guarantor's responsibility if this action becomes necessary.

A $50.00 office fee will be charged for missed appointments or appointments cancelled with less than 24 hour notice. Insurance companies, including Worker's Compensation **will not** pay missed appointment fees.

_____

Patient/Guardian Signature Date

I hereby authorize the following:

1. Treatment for myself or for the person listed on the **PATIENT INFORMATION FORM** by a physical therapist associated with OSPTA, Inc.
2. Assignment of insurance payment to OSPTA, Inc.
3. The release of any and all medical information to and/or from my treating physician and insurance carrier for the purpose of claims administration.
4. The release of testing results (e.g. x-ray, MRI) from my treating physician or any facility in which testing was performed to OSPTA, Inc.
5. If applicable, I also authorize release of information to my attorney (with a signed order) and payment on my account out of funds collected.

_____

Patient/Guardian Signature Date

NOTICE OF PRIVACY PRACTICES

This notice describes how your personal health information may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment include therapeutic procedures, ultrasound treatments, gait analysis, etc.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance plan for your physical therapy services.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be a periodic assessment of our documentation protocols.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected information when required by federal, state or local law. We may disclose your protected information to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law including but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your protected health insurance information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release protected health information to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We use and disclose your protected health information when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your protected health information if you are member of US or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your protected health information to federal officials for intelligence and national security activities authorized by law. We may disclose your protected health information your protected Health information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your protected health information to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your protected health information for workers' compensation or other similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have certain rights in regards for your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below. Your rights include:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, to inspect, and to copy your protected health information.
- The right to request an amendment to your protected health information.
- The right to receive an accounting of disclosure of protected health information outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective day and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information regarding our Privacy Practices, please contact:
Teresa Haynes
Orthopedic & Sports Physical Therapy Associates, Inc
421 Chatham Square
Fredericksburg, VA 22405 Phone: 540-373-3031

For more information about HIPAA or to file a complaint:
The US Department of Health & Human Services Office of Civil Rights 200 Independence Avenue, SW
Washington, DC 20201 Phone: 877-696-6775

I, _____
have reviewed a copy of Orthopedic & Sports Physical Therapy Associates' Notice of Privacy Practices with an effective date of April 1, 2003.

_____
Signature of Patient/Date