ADVANCED BENEFICIARY NOTICE
TOTAL PHYSICAL THERAPY

6933 South 66th East Ave
Tulsa, OK 74020
Phone: (918)495-0600
Facsimile: (918)496-2146

1. I hereby authorize and request that payment of benefits by my primary (and secondary insurance, if any) be made directly to Total Physical Therapy for services furnished to me or my dependent. I understand that my insurance company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment. In addition, I authorize Total Physical Therapy to disclose any and all written information from the above-named insurance company and/or its designated representatives for reimbursement purposes for those services received. I hereby release Total Physical Therapy, its officers, agents, employees and any clinical staff associated with my case, from all liability that may arise as a result of disclosure of information to the above-named insurance company(s) or their designated representatives.
2. I understand that, unless 100% coverage has been verified, I am responsible for the percentage &/or deductible not covered by My insurance company. This payment is requested during each visit.
3. I understand that if insurance information is not available, I do not have insurance, or if my insurance does not reimburse, payment is due in full at the time of service unless other arrangements have been approved by the Centralized Billing Office (CBO.)
4. I understand that there is a $25 charge for all returned checks.

Signature _____ **Date** _____

Total Physical Therapy

6933 S. 66th E Ave. Tulsa, OK 74133 Phone# 918-495-0600 Fax# 918-496-2146

PATIENT INFORMATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name:	First: MI:	Date:	Marital status (circle one) Single / Mar / Div / Sep / Wid

Birth date: / /	Primary Care Physician:	Age:	Sex: ☐ M ☐ F

Street address:	City:	State & Zip:

Cell Phone #	Home phone#	Work #	Social Security #

Email Address:

Chose clinic because/Referred to clinic by (please check one box): ☐ Dr. _____

☐ Family ☐ Friend ☐ Close to home/work ☐ Yellow Pages ☐ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card or Cards to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Subscriber's name:	Subscriber's S.S.:	Birth date: / /	Group no.:	Policy no.:

Name of secondary insurance (If applicable): Subscriber's name:

Group no.: Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Cell phone #. Or Other ( )

The above information is true to the best of my knowledge. I authorize my Insurance benefits be paid directly to Total Physical Therapy. I understand that I am financially responsible for any balance. I also authorize Total Physical Therapy or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian Signature *Date*

Total Physical Therapy

6933 S. 66th E Ave. Tulsa, Ok 74133 Phone# 918-496-0600 Fax# 918-496-2146

TOTAL PHYSICAL THERAPY PRIVACY PRACTICE
EFFECTIVE APRIL 14, 2003

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

The terms of this Notice of Privacy Practices apply to Total Physical Therapy. Total Physical Therapy will share personal health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law. We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to personal health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make a new Notice effective for all personal health information maintained by Total Physical Therapy. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act. A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained my mailing a request to Total Physical Therapy, 6933 South 66th E. Ave Tulsa, Ok 74133.

USES AND DISCLOSURES OR YOUR PERSONAL HEALTH INFORMATION

Authorization and Consent: Except as outlined below, we will not disclose your personal health information for any purpose other than treatment, payment, or health care operations unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have acted in reliance on the authorization.

USES AND DISCLOSURES FOR TREATMENT

With your agreement, we will make uses and disclosures of your personal health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc.

USES AND DISCLOSURES FOR PAYMENT

With your agreement, we will make uses and disclosures of your personal health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may use your information to prepare a bill to send to you or the person responsible for your payment.

USES AND DISCLOSURES FOR HEALTH CARE OPERATIONS

With your agreement, we will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation, and licensing, etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and patient care.

INDIVIDUALS INVOLVED IN YOUR CARE

With your written agreement, we may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that the person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with involved individuals without your approval. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

BUSINESS ASSOCIATES

Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditations, outcomes data collections, legal services, etc. At times it may be necessary for us to provide your personal healthy information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require this business associated to appropriately safeguard the privacy of your information.

APPOINTMENTS AND SERVICES

We may contact you to provide appointment reminders or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to an address, we will accommodate reasonable request. You also have the right to request that we not send you any further marketing materials and we will use our best efforts to honor such. You may make you requests by sending your name and address to Total Physical Therapy at 6933 S. 66th E. Ave Tulsa, Ok 74133.

RESEARCH

In limited circumstances, we may use and disclose your personal health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an institutional review board which oversees the research or by representations of the researchers that limit their use and disclosures of patient information.

OTHER USES AND DISCLOSURES

We are permitted and/or required by law to make certain other uses and disclosures of your personal health information without you consent or authorization for the following:

- Any purpose required by law
- Public health activities, such as required reporting of disease, injury, birth and death, or required public health investigations.
- If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect, or domestic violence.
- To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls.
- To your employer when we have provided health care to you at the request of your employer.
- To the government oversight agency conducting audits, investigations, or civil or criminal proceedings.
- Court or administrative ordered subpoena or discovery request.
- To law enforcement officials as required by law to report wounds and injuries and crimes.
- To coroners and/or funeral directors consistent with law.
- If you are a member of the military; we may also release your personal health information for national security or intelligence activities.
- To Workers' Compensation agencies for Workers' Compensation benefit determination.

RIGHTS THAT YOU HAVE REGARDING YOUR PERSONAL HEALTH INFORMATION

ACCESS TO YOUR PERSONAL HEALTH INFORMATION

You have the right to copy and /or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information" from Administrative Supervisor. You are entitled to one free copy of your personal health information. If you request additional copies you may be charged a nominal fee for copying and postage.

AMENDMENTS TO YOUR PERSONAL HEALTH INFORMATION

You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, must be in writing, signed by you or your legal representative, and must state the reasons for the amendment/ correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the Administrative Supervisor or person responsible for medical records.

RESTRICTIONS ON USE AND DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION

You have the right to receive an accounting of certain disclosures made by us of your personal health information after April 14, 2003. Request must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the Administrative Supervisor or personal responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

RESTICTIONS ON USE AND DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION

You have the right to request restrictions on uses and disclosures of your personal health information for treatment, payment, or health care operations. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the individual responsible for medical records.

COMPLAINTS

If you believe your privacy rights have been violated, you can file a complaint in writing with Total Physical Therapy 6933 S. 66th E. Ave Tulsa, Ok 74133. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your right. There will be no retaliation for filing a complaint.

Patient (or representative) Signature _____ Date _____

Total Physical Therapy
6933 S. 66th E Ave. Tulsa, OK 74133 Phone# 918-495-0600 Fax# 918-496-2146

ADMISSION SCREENING FORM

We are interested not only in your physical well being, but also in any problems that have arisen due to your illness and/or injury. Because our goal for you is improved functioning and recuperation, we offer the services of a professional social worker, vocational guidance, and support and counseling to assist you in your recovery.

Please take a moment to answer the following questions so that our social worker can evaluate your situation and offer assistance.

Patient's Name: _____

1. Do you have transportation to our facility?
   Yes_____ No_____

2. Are you presently employed? Yes_____ No_____

3. Does your illness/injury prevent you from making a living?
   Yes_____ No_____

4. Do you have a spouse and/or children dependent on you?
   Yes_____ No_____

5. Are you retired? Yes_____ No_____

6. How long have you lived in this area? _____

7. Do you have family or friends in the area that are able to assist you when needed?
   Yes_____ No_____

8. If you are a student, has your illness/injury interfered with your schooling?
   Yes_____ No _____

9. Would you like to be referred to our staff social worker?
   Yes_____ No_____

Total Physical Therapy
6933 S. 66th E Ave. Tulsa, OK 74133 Phone # 918-495-0600 Fax # 918-496-2146

PATIENT CANCELLATION AND NO-SHOW POLICY

Your scheduled appointment is a specific time when your therapist will spend time with you. It is extremely important to be punctual. If you are unable to attend, **YOU MUST NOTIFY US IN ADVANCE AND RESCHEDULE TO MAKE UP THE MISSED APPOINTMENT**. Failure to attend your session may hinder your recovery process as well as disrupt the schedule of your therapist.

CANCELLATION: Three consecutive cancellations will result in termination of your therapy program. To restart your therapy, you must return to your physician for a new prescription and obtain additional authorization from your insurance provider. **YOUR CANCELLATION WILL BE CLASSIFIED AS NO-SHOW IF YOU DO NOT NOTIFY THE OFFICE AT LEAST 12 HOURS PRIOR TO YOUR APPOINTMENT.**

No Show: If you No-Show to any appointments, **you will be charged a $30 fee** that is not billable to your insurance and is due at the time of your appointment. To restart your therapy, you must return your physician for a new prescription and obtain additional authorization from your insurance provider.

IF YOU ARE COVERED BY WORKER'S COMPENSATION and fail to keep the appointment as recommended by your physician, the appropriate parties will be notified of your absence in writing. Typically, the notification will be to your physician, insurance carrier, employer, and rehabilitation consultant. Each cancelled and no-show appointment will also be noted in your chart. Please understand that failure to actively participate in your rehabilitation program may result in the impression that you are disinterested in your recovery and/or are better and able to return to work. Failure to attend therapy may have negative effect on your worker's compensation coverage. Thank you.

Patient Signature:_____ Date:_____

Total Physical Therapy

6933 S. 66th E Ave. Tulsa, OK 74133 Phone# 918-495-0600 Fax# 918-496-2146

BILLINGS DISCLOSURES TO INDIVDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call Total Physical Therapy to inquire about your personal health information or billing information. Please take a few moments to complete this form.

I authorize Total Physical Therapy to disclose my health information that is directly related to my current treatment at Total Physical Therapy to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

Such persons involved in your care may include spouses, children, blood relatives, roommates, boyfriends or girlfriends, domestic partners, neighbors, and colleagues.

NAME	RELATIONSHIP

I do not wish to have my health information disclosed to the following individuals involved in my care.

NAME	RELATIONSHIP

Signature of Patient (or Patient's Representative) **Date**

If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:

- ☐ Power of Attorney
- ☐ Executor of Legal Rep.
- ☐ Guardian
- ☐ Parent
- ☐ Surrogate Decision-Maker
- ☐ Other (please specify)_____

Provide documentation or explanation of your authority to act for the patient:

_____

_____

Total Physical Therapy

6933 S. 65th E Ave. Tulsa, OK 74133 Phone# 918-495-0600 Fax# 918-496-2146

PAYMENT POLICY & BILLING PROCEDURES

1. I hereby authorize and request that payment of benefits by my primary and secondary insurance (if any) be made directly to **Total Physical Therapy** for services furnished to me or my dependent. I understand that my insurance company may only cover a portion of the total bill. I further understand that I may be responsible for all charges not covered by this assignment. In addition, I authorize Total Physical Therapy to disclose any and all written information from the above-named insurance company and/or its designated representatives for reimbursement purposes for those services received. I hereby release **Total Physical Therapy**, its officers, agents, employees and any clinical staff associated with my case, from all liability that may arise as a result of disclosure of information to the above-named insurance company(s) or their designated representatives.
2. I understand that, unless 100% coverage has been verified, I am responsible for the percentage &/or deductible not covered by My insurance company. This payment is requested during each visit.
2. I understand that if insurance information is not available or I do not have insurance, **payment is due in full** unless other arrangements have been approved by our Centralized Billing Office (CBO.)
3. I understand that there is a $25 charge for all returned checks.

INSURANCE INFORMATION

As a courtesy to our patients, we will verify and file your insurance, however; we cannot guarantee payment. We strongly suggest that you read you policy manual as it pertains to physical therapy coverage. Many insurance companies have stipulations, such as usual & customary fees (UCR), limited therapy sessions, limited reimbursable amounts per session, deductibles, co-payments, supplies, etc. Such stipulations should be indicated in your policy manual.

YOU ARE RESPONSIBLE FOR AMOUNTS NOT COVERED by your insurance. We have an agreement with YOU, not your insurance company, for receipt of payment. Please be aware of this and plan to make payments accordingly.

Worker's Compensation benefits will be verified, however; this does not guarantee payment. In the event of denial, this account will become **YOUR RESPONSIBILITY.**

CONSENT TO TREATMENT

I understand that I have been referred for rehabilitation treatment and care to a Total Physical Therapy Outpatient Rehabilitation Center. Total Physical Therapy has described for me my individual treatment plan. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has been prescribed by my physician and /or recommended by my therapist. By signing this agreement, I consent to have Total Physical Therapy Outpatient Rehabilitation provide treatment and care as prescribed and care as prescribed by my physician and/or recommendation by my therapist.

The statements are true and complete to the best of my knowledge. I understand, fully, the payments policy & billing procedures of Total Physical Therapy Outpatient Rehabilitation. I hereby authorize Total Physical Therapy Outpatient Rehabilitation to furnish my insurance company(s), attorney, or legal representative all information which said parties may request concerning my present illness or injury. I hereby assign Total physical Therapy Outpatient Rehabilitation all money to which I am entitled for medical expenses related to money received from the above-named parties over & above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to Total Physical Therapy Outpatient Rehabilitation for charges not covered by my insurance company. I certify by my signature that I have read and agree to this information.

Total Physical Therapy does not discriminate against any person based on race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services, or in employment. For further information about this policy, contact Curtis M. Hobbs, (918) 495-0600.

Signature:	Date:

Relationship to Patient (self, parent, guardian, spouse, etc.):

Witness:

Total Physical Therapy

6933 S. 66th E Ave. Tulsa, OK 74133 Phone# 918-495-0600 Fax# 918-496-2146

PAST MEDICAL HISTORY FORM

Patient Name: _____ Date: _____/_____/_____

Are you presently working? ☐ Yes ☐ No

Date of next physician's visit: _____ /_____ /_____

1. Date of injury/onset: _____/_____/_____

2. Have you ever had these symptoms before? ☐ Yes ☐ No

3. Check which apply to your current condition:
   ☐ work-related injury ☐ recurrence of previous injury ☐ motor vehicle accident
   ☐ injury related to lifting ☐ injury related to falling ☐ athletic/recreational
   ☐ cause unknown ☐ other: _____ ☐ injury

4. If female, are you pregnant? ☐ Yes ☐ No

5. Do you have, or have had any of the following:

	Yes	No		Yes	No
Diabetes	☐	☐	Hypoglycemia	☐	☐
Chest Pain/Angina	☐	☐	Osteoarthritis	☐	☐
High Blood Pressure	☐	☐	Osteoporosis	☐	☐
Heart Disease	☐	☐	Hernia	☐	☐
Heart Attack	☐	☐	Seizures	☐	☐
Heart Palpitations	☐	☐	Metal Implants	☐	☐
Pacemaker	☐	☐	Dizziness/Fainting	☐	☐
Headaches	☐	☐	Fractures	☐	☐
Problems Kidney	☐	☐	Surgeries	☐	☐
Cancer	☐	☐	Skin Abnormalities	☐	☐
Stroke	☐	☐	Nausea/Vomiting	☐	☐
Bowel/Bladder Abnormalities	☐	☐	Ringing in your ears	☐	☐
Urine Leakage	☐	☐	Rheumatic Arthritis	☐	☐
Asthma/Breathing Difficulties	☐	☐	Smoking	☐	☐
Liver/Gallbladder Problems	☐	☐	Other	☐	☐

If you answered Yes to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.

_____

_____

_____

6. Do you have any allergies? ☐ Yes ☐ No

If yes, please list your allergies:

7. Are you presently taking any medications? ☐ Yes ☐ No

If yes, please list what medications and for what condition:

Medication	Dosage

8. Do you participate in any sports, exercise programs or activities on a regular basis? ☐ Yes ☐ No

9. Have you had a related surgery? ☐Yes ☐ No

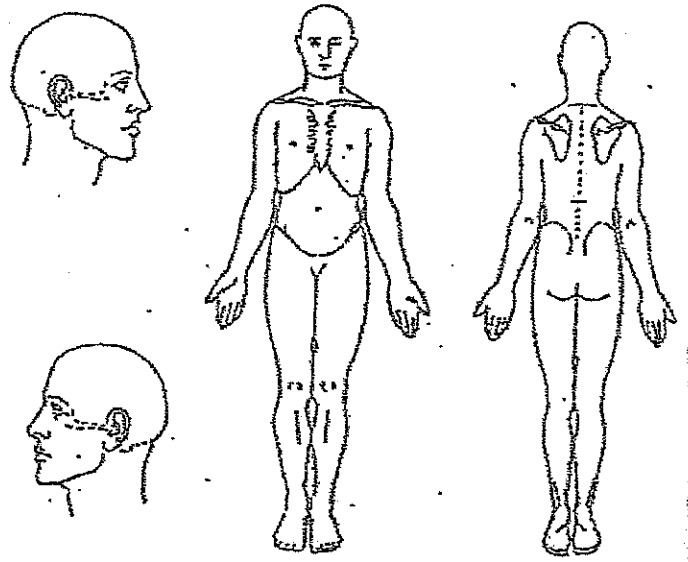
If yes, please list them below

Surgery	Date

Total Physical Therapy

6933 S. 66th E Ave. Tulsa, OK 74133 Phone# 918-495-0600 Fax# 918-496-2146

11. Please indicate below where your symptoms are located



12. If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible. Circle one.

Score:

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Consent to Treatment

I understand that I have been referred for rehabilitative treatment and care to Total Physical Therapy Rehabilitation Center. I understand that I have the right to ask and have any questions answered prior to receiving any treatment; including any risks or alternatives to the treatment plan. By signing this agreement, I consent to have Total Physical Therapy & Rehabilitation provide treatment and care as prescribed by my physician and/or recommended by my therapist.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Relationship to Patient _____

(parent, guardian, spouse, etc.)