Multidisciplinary
THERAPY

1410 Blanding St. STE 100
Columbia, SC 29201
Phone: (803)410-5483
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PATIENT INFORMATION FORM

☐ **OCCUPATIONAL THERAPY** ☐ **SPEECH THERAPY** ☐ **PHYSICAL THERAPY** ☐ **MUSIC THERAPY** ☐ **ART THERAPY**

☐ New Information

Patient's Name (as appears on insurance card): _____ DOB: _____

Male / Female Address: _____

Phone Number: _____ Cell Phone Number: _____

E-mail: _____ *Please circle preferred method of communication.

Diagnosis (if known): _____

Primary Physician: _____

Physician's Phone and Address: _____

How did you hear about Multidisciplinary Therapy Inc.?: _____

Insurance (Ins) Info

Primary Ins: _____ Name of Ins: _____

Insured Social Security: _____ DOB _____

Member ID _____ Group# _____

Customer Service phone _____ Claims Address (found on back of card): _____

_____

Consent to Treat

I, _____ for Multidisciplinary Therapy, Inc. to provide _____ with a Physical therapy evaluation and subsequent therapy services. I consent to care and treatment falling under the practice guidelines of the America and the State of South Carolina. I acknowledge that there is always a risk of injury with any therapy involving physical activities.

Signature: _____ Name: _____ Date: _____

Permission for Exchange of Information

I authorize Company Name to release necessary and pertinent medical information to physicians, case managers and insurance companies as needed.

Approved information may be exchanged with the following people directly related to the patient's care: ☐ Therapists ☐ School Officials ☐ Other _____

Signature: _____ Name: _____ Date: _____

Absences and cancellations

Multidisciplinary Therapy, Inc. strives to provide the highest quality of care while attempting to accommodate each patient's schedule. Therefore, we provide each patient a reserved time slot with specific therapist in order to minimize wait time and assure continuity of treatment. Consistent attendance and adherence to the planned treatment regimen is paramount to your child's success in therapy.

While we are sensitive to the fact that an emergency may occur, cancellations, tardiness and absentees reduce our ability to accommodate the scheduling needs of our patients. As such, we request your full cooperation with the following company policy:

- A Scheduled appointment MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE. A patient is allotted three cancellations with prior notification within a six month period.
- Failure to show up for a scheduled appointment without providing the clinic advanced notification of your child's absence will result in a NO SHOW for that appointment. Furthermore, 2 NO SHOW absences without advanced notification may result in the DISCHARGE of the patient.
- All cancellations and absences will be documented in your child's therapy record and reported to your physician and insurance company or third party payor. Your insurance requires your child to improve while receiving services. If your child frequently misses scheduled therapy appointments, your insurance will not approve additional visits due to lack of progress associated with missed visits, which will result in your child being discharged from treatment.
- Scheduling makeup appointments is strongly encouraged to ensure consistency in your child's treatment program but are only available per therapist availability.

Signature: _____ Name: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

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. If you have any questions about this notice, please contact Multidisciplinary Therapy at (803)410-5483.

Our Responsibilities
We are required by law to maintain the privacy of your health information and provide you with a description of our privacy practices. We will abide by the terms of this notice.

Uses and Disclosures
The following categories describe how we may use and disclose your medical information.

For Treatment: We may use health information about you to provide you treatment or services. This means providing, coordinating, or managing health care and related services by one or more health providers. An example of this would include a physical examination.

For Payment: We may use and disclose health information about your treatment and services for such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
For Health Care Operations: Members of our staff may use information in your health record for 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 an internal quality assessment review. We may disclose information to students for educational purposes. We may remove information that identifies you form this set of health information to protect your privacy. We may contact you to remind you that you have an appointment; assess your satisfaction with our services; tell you about possible treatment alternatives; tell you about health-related benefits or services; and we may leave messages on your answering machine or voice mail regarding primary appointment reminders and billing/collections efforts.

Future Communications: We may contact you in the future via newsletters, mail outs, or other means regarding treatment options, health related information, or other community based initiatives or activities our facility is participating in.

Organized Health Care Arrangement: This facility and its staff members have organized and carry out treatment, payment, and healthcare operations. Therapists and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

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

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the right to:

Inspect and Copy: You have the right to inspect and obtain a copy of your health information, including billing records.
Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our facility. Any request for an amendment must be sent in writing to the Facility Privacy Official.

An Accounting of Disclosures: You have the right to request and accounting of disclosures. This is a list of certain disclosures we make of your health information for purpose other than treatment, payment, or healthcare operations where an authorization was not required.

Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care (i.e., family member or friend). Any request for a restriction must be sent in writing to the Facility Privacy Official. We are required to agree to your request only if 1) except as otherwise required by law, the disclosure is to your health plan and the purpose related to payment of health care operations (and not treatment purposes), and 2) your information pertains solely to health care services for which you have paid in full. For other requests, we are not required to agree. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we contact you at work instead of at home or in a private room, rather than in the waiting room. The facility will grant requests for confidential communication at alternative locations and/or alternative means if the request is submitted in writing and the written request include a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

A Paper Copy of this Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Changes To This Notice
We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and on our website and include the effective date.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with this facility. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Other Uses of Health Information
Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us with permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you and documented in our facility.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Provide treatment and services
- Bill and collect payment from you, your insurance company, or a third party payer
- Conduct healthcare operations such as assess my care and outcomes as well as quality assessments

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of my rights and the uses and disclosures of my health information. I understand that Multidisciplinary Therapy, Inc. has the right to change its Notice of Privacy Practices and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that Multidisciplinary Therapy, Inc. restricts how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that this organization is not required to agree to my requested restrictions, but if the organization does agree then it is bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Financial and Insurance Policy

- A copy of your driver's license and insurance information is required before services begin. Benefits will be verified upon receipt of your insurance information and you will be made aware of any **estimated** out-of-pocket expenses before any services are started. Information obtained from insurance companies is **not always a guarantee of payment**. Families are ultimately responsible for payment for non-covered services. **It is imperative that families are aware of their insurance coverage and their potential responsibilities**. We will strive to keep open communication in regards to insurance and payment. Families will inform *Multidisciplinary Therapy, Inc*. of any changes regarding insurance. Families assign benefits for filed claims to be paid to *Multidisciplinary Therapy, Inc*. Any payment sent directly to the family, intended to cover therapy services provided by *Multidisciplinary Therapy, Inc*., should be given promptly. _____ parent initials
- The usual and customary rate for services is billed to insurance. If we bill your insurance and you have a deductible, the **full amount applied to your deductible will be billed to you.** We do accept Medicaid and private insurance for **Physical therapy** services and responsibilities are determined by plan. *Multidisciplinary Therapy, Inc*. accepts cash, and check, There is a $50 fee for all returned checks. _____parent initials
- We submit claims to insurance within one month of service dates. If payment has not been received within 60 days, the family will be responsible for the balance. If insurance makes payment, the family will be reimbursed any money that was paid for these services. If a family receives a bill that is not paid within 30 days of receipt of invoice, there will be a **10% late fee** added, and services risk being put on hold. _____parent initials
- *Multidisciplinary Therapy, Inc*. will file all **Physical therapy** claims per our agreements with each insurance company. Please contact us to get an updated list of companies with whom we are in network. If authorization is required, therapists will submit based on need. Services will be administered after approval has been obtained. _____parent initials
- For parents requesting to pay out of pocket, an initial evaluation for **Physical therapy** services is $180/hour. An initial evaluation will be needed for all children starting therapy with our facility. Most evaluations will last 1 hour. If a family needs a re-evaluation for insurance or personal reasons, the rate will be $160/hr. Financial arrangements will be made prior to the time of evaluation. _____parent initials

Signature: _____ Name: _____ Date: _____

Medical History Form

Patient Name: _____ Height: _____ ft _____in

Weight:_____(pounds) Date of injury:_____

Diagnosis as stated to you by your physician: _____

How did this injury/ exacerbation occur? _____

Have you been hospitalized for the present condition? □ Yes □ No If Yes, date: _____

Have you had surgery for the present condition? □ Yes □ No If Yes, date: _____

If yes, surgery type:_____

Have you had any falls this past year? □Yes □No If Yes, how many?_____ Have you received previous treatment for this condition? □ Yes □ No If Yes, date: _____

If yes, please summarize: _____

Have you ever had any of the following? □ EMG □ CT SCAN □ MYELOGRAM □ MRI □ XRAY

Have you ever, or are you presently being treated for any of the following conditions?

Acquired Respiratory Distress Syndrome	□ Yes	□ No	Allergies	□ Yes	□ No
Angina	□ Yes	□ No	Headaches	□ Yes	□ No
Anxiety or Panic Disorders	□ Yes	□ No	Back Injury	□ Yes	□ No
Arthritis (RA, OA)	□ Yes	□ No	Bleeding Disorders	□ Yes	□ No
Asthma	□ Yes	□ No	Cancer	□ Yes	□ No
Chronic Obstructive Pulmonary Disease (COPD)	□ Yes	□ No	Bowel / Bladder Abnormalities	□ Yes	□ No
Congestive Heart Failure (CHF)	□ Yes	□ No	Dizzy or Fainting Spells	□ Yes	□ No
Degenerative Disc Disease (back disease, spinal stenosis, severe chronic back pain)	□ Yes	□ No	Epilepsy or Seizure Disorder	□ Yes	□ No
Depression	□ Yes	□ No	Fracture	□ Yes	□ No
Diabetes	□ Yes	□ No	Hepatitis A, B, C	□ Yes	□ No
Emphysema	□ Yes	□ No	Hernia	□ Yes	□ No
Hearing Impairment	□ Yes	□ No	High Blood Pressure	□ Yes	□ No
Heart Attack	□ Yes	□ No	Hypoglycemia	□ Yes	□ No
Multiple Sclerosis	□ Yes	□ No	Immunosuppressant Condition or Medication	□ Yes	□ No

Osteoporosis	□ Yes	□ No	Nausea / Vomiting	□ Yes	□ No
Parkinson's Disease	□ Yes	□ No	Pacemaker	□ Yes	□ No
Peripheral Vascular disease	□ Yes	□ No	Pregnancy	□ Yes	□ No
Stroke or TIA	□ Yes	□ No	Ringing in Your Ears	□ Yes	□ No
Upper Gastrointestinal Disease (ulcer, hernia, reflux)	□ Yes	□ No	Sexual Dysfunction	□ Yes	□ No
Visual Impairment (cataracts, glaucoma, macular degeneration)	□ Yes	□ No	Skin Abnormalities	□ Yes	□ No
Kidney Problems	□ Yes	□ No	Smoking	□ Yes	□ No
Liver / Gallbladder Problems	□ Yes	□ No	Special Diet Guidelines	□ Yes	□ No
Metal Implants	□ Yes	□ No	Tuberculosis	□ Yes	□ No

Patient Name: _____

To help us understand your symptoms, please circle all that apply.

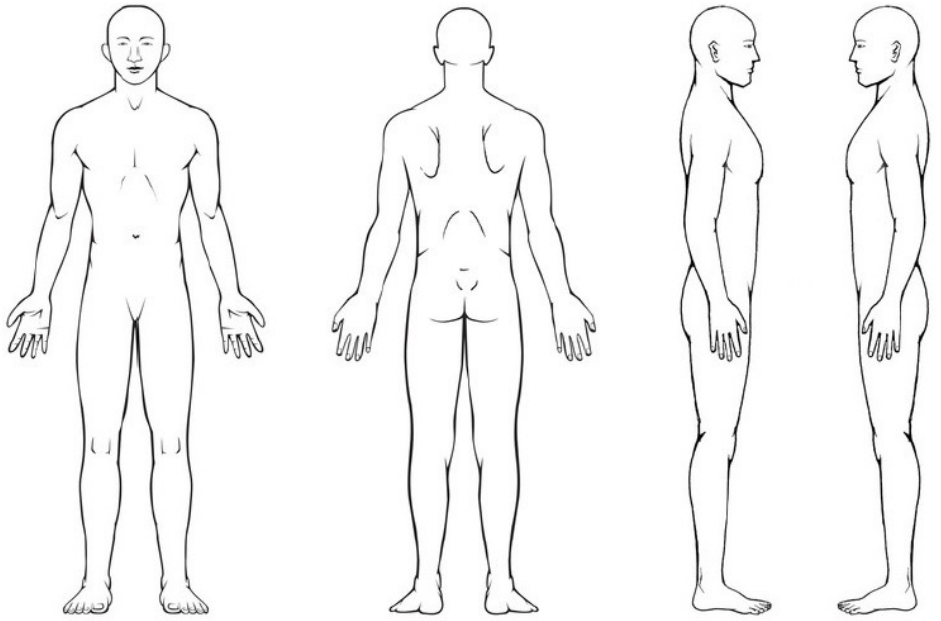
My pain is worse: in the morning/ during the day/ at night/ constant/ with activity/ during rest

On a scale of 0 to 10 (0 being no pain and 10 being unbearable pain requiring hospitalization)

Please rate your pain at its best _____ and at its worst_____

Pain Diagram

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition



Key

↑ or ↓ Radiating Pain

XXX Spasm

ZZZ Tenderness

//// Numbness/Tingling

000 Ache/Pain

Is there any other information regarding your medical history that we should know about? _____

_____

What is your goal for therapy at this time? _____

_____

Signature of Patient or Guardian (if patient is a minor): _____ Date: _____

Signature of Clinician: _____ Date: _____