PJ Therapy Services, Inc.

114-C College Avenue • Elberton, Georgia 30635 • 706-213-8506

How Did You Hear?

We would like to take the time to personally thank individuals for recommending patients to PJ Therapy Services, Inc. Please select one of the options below so that we know who to thank.

- ☐ I am former patient of PJ Therapy Services, Inc.
- ☐ My doctor suggested that I would benefit from therapy and recommended that I attend PJ Therapy Services, Inc.
- ☐ The following friend/family (_____) recommended that I utilize PJ Therapy Services, Inc for my therapy needs.
- ☐ I heard about your services from a different source _____.

This information is greatly appreciated and will allow us to show our gratitude towards those individuals who support our clinic.

PJ THERAPY SERVICES, INC

Date: _____

Welcome to our office. We will do our best to make your appointment as convenient and pleasant as possible. If at any time you have questions regarding your treatment, your appointments, or charges, please feel free to ask. The following information will be appreciated and will be used in strict confidence to prepare your clinical chart.

Mr./Mrs./Miss _____ Date of Birth _____ Age: _____
Street Address: (No P.O. Box Please) _____
City _____ State _____ Zip _____
Cell Phone ( )_____ Social Security No. _____ Sex M F
Home Phone ( ) _____ Email Address:_____
_____ Married _____ Divorced _____ Single _____ Widow _____ Other

Employer _____ Occupation _____ Bus Phone _____
Employer Address _____ City_____ St _____ Zip _____

Secondary Contact Person _____ Relationship to Patient _____
Employer of Contact Person _____ Employer Phone _____

Person Responsible for Account _____ Phone _____
Address _____ St _____ Zip _____
Have you or a family member ever been a patient in our office before? No Yes: Who? _____

PJ THERAPY SERVICES PAYMENT POLICY AND BILLING PROCEDURES

PAYMENT POLICY: WE REQUEST PAYMENT OF CO-PAY AMOUNT AFTER EACH THERAPY SESSION.
INSURANCE: WE WILL FILE YOUR PRIMARY INSURANCE FOR YOU IF YOU WILL PROVIDE THE APPROPRIATE INSURANCE INFORMATION.
WORKER'S COMPENSATION: PLEASE PROVIDE THE PROPER INFORMATION REQUIRED TO VERIFY COVERAGE. WE WILL SUBMIT ALL CHARGES TO YOUR WORKER'S COMPENSARTION CARRIER RESPONSIBLE FOR ACCOUNT BALANCE.
LEGAL CASES: WE WILL DISCUSS TREATMENT ON CONTINGENCY BASIS BUT WILL ASK THAT YOU PAY A PERCENT AGE OF YOUR ACCOUNT AT EACH TREATMENT SESSION.

CONSENT FOR TREATMENT AND AUTHORIZATION

The statements contained herein are true and complete to the best of my knowledge. I understand fully the payment policy and billing procedures of PJ Therapy Services, Inc. I hereby authorize PJ Therapy Services, Inc to furnish my insurance company, attorney or legal representation all information which said parties may request concerning my present illness or injury. I do hereby consent for treatment at PJ Therapy Services and authorize them to release whom I direct any information acquired in the course of my treatment. I further authorize insurance benefits to be paid directly to PJ Therapy Services when indicated on claim. I understand I am financially responsible to PJ Therapy Services for charges not covered by my insurance company. I certify by my signature that I have read and agree with this information.

A PHOTOSTATIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL

Signed _____ Date _____ Signed_____
(Patient) (If Minor, parents signature)

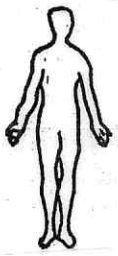
Signed _____ Date _____
(Responsible Party if different)

PATIENT INFORMATION/HISTORY

Name: _____ Today's Date: _____
Age: _____ Referring Doctor: _____ Next Dr. Appt: _____
Diagnosis/Treatment Problem: _____
When (date) did you first notice the pain or have functional problems due to the injury? _____
How did your pain/injury occur? _____
Is your pain constant or does it come and go? _____
On a scale of 0-10 (0= no pain, 10= the worst pain you can imagine), rate the following:
Worst pain thus far _____ Least pain thus far _____ Today's pain _____
What do your symptoms feel like? (i.e. sharp, ache, numb, throb, etc.) _____
Please indicate on diagram the area of your pain:

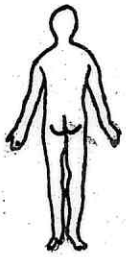
Front

Right Left



Back

Left Right



Have you been treated for this before? Yes No
Have you received any surgery for your injury/condition? _____
Have you received any injections for your injury/condition? Yes N When? _____ Did it help? Y N

Have you ever experienced/diagnosed with any of the following?

Tuberculosis	Yes No	Epilepsy	Yes No	Arthritis	Yes No	Diabetes	Yes No
Heart Condition	Yes No	Stroke	Yes No	Hepatitis	Yes No	Breathing Problems	Yes No
Currently Pregnant	**Yes No**	High BP	Yes No	**Cancer**	**Yes No**	Liver Problems	Yes No
HIV/AIDS	Yes No	Anemia	Yes No	Fractures	Yes No	Metal Implants	Yes No
Stomach Problems	Yes No	Swelling	Yes No	**Pacemaker**	**Yes No**	Kidney Problems	Yes No
Leukemia	Yes No	Radiation	Yes No	Chemotherapy	Yes No	Blood Disorders	Yes No
Joint Replacement	Yes No	Osteoporosis	Yes No				

Other Medical Conditions: _____
Have you fallen within the past year? Y N If yes: How many times _____ Were you injured? Y N
Do you smoke? Yes No Latex Allergy: Yes No
List any diagnostic tests that you have had for this condition (x-ray, MRI, etc.) _____
What do you hope to accomplish with therapy? _____
_____
Are you currently employed? Yes No If yes: Are you currently working Full Duty, Light Duty or Not Working
Are you on disability? Yes No If yes, for what condition/reason _____
Is this injury work related? Yes No
What are the physical requirements of your job? _____

MEDICATION LIST

Medication	Dosage (i.e. mg)	Frequency (times per day)

***Medication Allergies: _____

PATIENT REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR REQUEST FOR CONFIDENTIAL COMMUNICATION

Patient name: _____ Phone Number _____ (Day)
_____ (Evening)

Patient Address: _____

_____
(City) (State) (Zip)

Request for Restriction

Medical information to be Restricted: _____
_____
_____

Nature of Restriction: _____
_____
_____

Request for Confidential Communication

Medical Information to be Communicated Confidentially: _____
_____

Alternative Location/Address/Telephone Number/E-mail: _____
_____

TO OUR PATIENTS: You may request that we restrict our use and disclosure of your medical records and information. Although the law does not require us to agree to your requested restrictions, if we do agree, we will comply with the restrictions unless a medical emergency or law requires otherwise. You also have the right to request that we communicate certain medical information to you in confidence. We will accommodate your reasonable written request to receive communications of medical information by alterative means or at alternative locations only if you (1) provide us with the alternative location, address, or telephone number and/or the alternative means of contact and (2) agree to be responsible for and explain how payment will be handled for any additional costs associated with the alternative method of communication.

By signing below, you state that you understand and agree to the above information.

Signature of Patient _____ Date _____

□ Request for Restriction **Accepted**
□ Request for Restriction **Denied**
□ Request for Communicate Confidentiality **Accepted**
□ Request for Communicate Confidentiality **Denied**

This Request for Restriction and Confidential Communication Form is to Be Made a Part of the Medical Record of: _____ _____
(Patient Name) (Date)

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE
(To be retained by Medical Provider)

I understand that PJ Therapy Services, Inc.(referred to below as "the clinic" will use and disclose **health information** about me in the course of providing rehabilitation care to me.

I understand that my **health information** may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand that the clinic is permitted to **use and disclose** my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult and coordinate with other health care providers in the course of my treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support the clinic's ability to provide me with appropriate care and arrange for payment.

I also understand that I have the right to receive a written **Notice of Privacy Practices** that describes how the clinic uses and discloses health information, the information practices followed by the clinic staff and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request. I also understand that a copy or a summary of the most current version of the clinic's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the clinic is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I <u>have received</u> a copy of the Notice of Privacy Practices.

By: _____ Date: _____
(Patient)

-OR-

By: _____ Date: _____
(Patient representative)

Description of Representative's Authority: _____

Attachment A

P J Therapy

PATIENT FINANCIAL RESPONSIBILITY FORM

Patient Name: _____ Date of Service: _____

INDIVIDUAL'S FINANCIAL RESPONSIBILITY

I understand the following:

- I am financially responsible for my cost-sharing obligation, as further detailed below.
- Co-payments are due at the time of service.
- If my health insurance plan requires a referral, I must obtain such a referral prior to my visit.
- In the event that my health insurance plan determines a service to be non-covered or "not payable," I will be responsible for the entire charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

**Practice will designate the applicable category, which must be signed and dated by the patient.*

☐ I understand that Practice is in-network with my health insurance plan and I am receiving **non-COVID-related** healthcare items and services. As such, I will be financially responsible for my cost-sharing portion associated with the services I receive, including, but not limited to deductible amounts, copayments, or payment for services deemed not covered by my health insurance plan.

Patient Initials: _____

☐ I understand that Practice is in-network with my health insurance plan and I am receiving **COVID-related** healthcare items and services. Pursuant to the Family First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief, and Economic Security Act (the CARES Act), my health insurance plan is responsible for covering 100% of these items and services and I should not be responsible for any cost-sharing obligation. However, in the event my healthcare insurance plan does not cover all or any portion of these services, I will be financially responsible for any outstanding amounts.

Patient Initials: _____

☐ I understand that Practice is out-of-network with my health insurance plan and I am receiving **non-COVID-related** healthcare items and services. As such, I understand that I will be "balance-billed" and will be financially responsible for my cost-sharing portion associated with the services

I receive, including, but not limited to deductible amounts, copayments, or payment for services deemed not covered by my health insurance plan.

Patient Initials: _____

☐ I understand that Practice is out-of-network with my health insurance plan and I am receiving **COVID-related** healthcare items and services. Pursuant to the FFCRA and the CARES Act, my health insurance plan is responsible for covering 100% of these items and services and I should not be responsible for any cost-sharing obligation. In the event my health insurance plan determines I am responsible for any cost-sharing obligation, Practice will only charge me an amount equal to the cost-sharing obligation if Practice was in-network with my health insurance carrier. In the event my healthcare insurance carrier deems the services non-covered or not payable, I will be responsible for the cost of such services.

Patient Initials: _____

☐ I am uninsured and will be responsible for full payment of the medical services rendered to me at the time of service.

Patient Initials: _____

INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize assignment of financial benefits directly to Practice and its associated healthcare entities for services furnished to me by the Practice. I understand that I am financially responsible for charges not covered by this assignment.

AUTHORIZATION TO RELEASE RECORDS

I authorize the Practice to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for pre-certification, authorization, or referral to other medical provider.

ACKNOWLEDGMENT

I have read and understand this Financial Responsibility Form described above. I agree to pay promptly and in full the amounts due to the Practice for all items and services.

Signature: _____ Date: _____
Patient, Authorized Representative or Responsible Party

Print Name: _____ Relationship to Patient: _____
Patient, Authorized Representative or Responsible Party