PATIENT INFORMATION: PLEASE COMPLETE ALL INFORMATION AND SIGN BELOW:

Patient Name:(Last)_____(First):_____(Middle):_____
Address:_____City:_____State:____Zip:_____
Home Phone:( )_____Cell Phone:( )_____
Date of Birth:____/_____/_____Age:_____ Sex: **Male** **Female** Marital Status: **S M W D**
SS #:_____/____/_____ Email:_____

Employer:_____Occupation:_____Work Phone:_____
Employer Address:_____City:_____State:_____ZIP:_____

Spouse/Parent Name:_____SS#:_____/_____/_____
Phone:( )_____Spouse/Parent Employer:_____
Emergency Contact:_____Relationship:_____Phone:( )_____

Referring Physician Name:_____ Date Last Seen:_____/_____/____

Have you been seen at Southern Therapy before? **YES / NO** When?_____
Have you received previous therapy any this year? **YES / NO** When?_____
If you have received therapy this year, have you been seen by Home Health? **YES / NO**
If you have received any Home Health service, please list discharge from Home Health service date:_____

<u>*PLEASE PRESENT COPIES OF CURRENT INSURANCE CARDS TO FRONT DESK*</u>

Insurance Type: **AUTO** **MEDICARE** **WORKERS COMP** **REGULAR INS.** **CASH**

Are you eligible for Medicare benefits? **YES** **NO** As **PRIMARY** or **AS SECONDARY**?
Insurance Name:_____Customer Service Phone: ( )_____
Insured Name:_____Medical Problem:_____
Social Security # of Insured:____/_____/_____Relationship to Insured:_____
Insured's DOB:____/____/_____Employer Name:_____
Policy # / Medicare #:_____Group #:_____
Employer/ WC Phone: ( )_____Employer/ WC Contact:_____
Date of Injury:____/_____/_____Claim W/C #:_____

The statements are true and complete to the best of my knowledge. I fully understand the payment policy and billing procedures of Southern Therapy Services, Inc. I hereby authorize Southern Therapy Services, Inc. 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 to Southern Therapy Services, Inc., all money to which I am entitled for medical expense relative to the service reported herein. I understand that I am financially responsible to Southern Therapy Services, Inc. for charges that are not covered by my insurance company. I understand my physician has referred me to therapy and hereby agree to the treatment and/or test procedures felt necessary by my physician and therapist. **I CERTIFY BY MY SIGNATURE THAT I HAVE READ AND AGREE TO THIS POLICY. I AUTHORIZE INFORMATION TO BE RELEASED FOR UTILIZATION AND QUALITY REVIEW PURPOSES. A PHOTOSTATIC COPY OF THIS AUTHORIZATION WILL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.**

_____ _____/_____/_____
PATIENT SIGNATURE DATE

_____ _____/____/_____
IF MINOR, PARENT SIGNATURE DATE

SOUTHERN THERAPY FINANCIAL POLICY

We do everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our payment policy. **ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE.**

Payment for all co-pays, percentages, deductibles, and any non-covered procedures is required at the time services are rendered. Southern Therapy Services accepts cash, local personal checks, all major credit cards, and Care Credit. There is a service charge for returned checks.

Please be advised that all returning patients with an outstanding balance of 60 days overdue must make arrangements for payment in full prior to scheduling an appointment.

INSURANCE:

ALL CO-PAYS AND PERCENTAGES ARE DUE AT THE TIME SERVICES ARE RENDERED.

Your insurance is a contract between you and your carrier. You are ultimately responsible for your charges. Our company accepts almost all types of insurance. Some policies are limited on their coverage; it is your responsibility to check with your insurance on limitations. Limitations may include, but not limited to, non-covered procedures and visit limits. We strive to bring you the highest quality of rehabilitative care at the lowest cost available. However, we are a business and must meet our own needs; therefore, we ask that all patients settle their accounts promptly. For your convenience, we gladly accept cash, check, or credit card. Please let us know if you have any questions regarding your financial responsibility.

Southern Therapy Services, Inc. does not accept attorney liens, bill third party insurance, or accept Medicaid for anyone 21 and over.

CASH PATIENTS:

In an effort to contain costs to cash only patients, balances cannot exceed $250.00. Any amount in excess of $250.00 will result in payment on the account in full before anymore visits can be scheduled.

As a courtesy; patients with no insurance who pay in full each visit, will receive a 20% discount.

WORKER'S COMPENSATION:

If you claim worker's compensation benefits and are denied such benefits, you will be held responsible for the total amount of charges rendered to you.

MEDICARE:

As a courtesy to our patients, we file all Medicare Part B claims electronically. We also file any supplemental policies to Medicare with the exception of adult Medicaid. If you do not have a supplemental policy, you are responsible for any percentages due according to our contractual Medicare fee schedule.

PATIENT CREDITS:

Southern Therapy strives to accurately collect insurance copays, deductibles, and percentages correctly the first time. However, due to numerous insurance plans and specifications, there may be times where you incur a patient credit. Upon discharge from STS, our insurance professionals will review each account to identify that all funds have been collected and dispersed appropriately. If patient credit is due, an acknowledgement will be mailed to the address on the account for you to sign and return.

MISSED APPOINTMENTS/LATE CANCELLATIONS:

Broken appointments represent a cost to us, to you, and to other patients who could have been seen at the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge $25.00 for missed or late-cancelled appointments. Excessive abuse of scheduled appointments will result in discharge from treatment.

PRIVACY NOTICE:

Southern Therapy Services, Inc. will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other healthcare operations. We have prepared a detailed NOTICE OF PRIVACY to help you better understand our policies in regards to your personal health information. By signing below, I hereby acknowledge I have read Southern Therapy Services, Inc. Privacy Notice.

I have read and understood the Southern Therapy Services, Inc. Financial Policy. I agree to assign insurance benefits to Southern Therapy Services, Inc. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

_____ _____

Signature of Patient/Responsible Party **Date**

_____ _____

Southern Therapy Services Representative **Date**

Only to be completed by Southern Therapy Services, Inc.:

After a good faith attempt to obtain an Acknowledgment of receipt, the patient or representative refused to sign or was unable to sign the Privacy Notice for the following reason(s):_____
_____
_____

_____ _____/_____/_____

SOUTHERN THERAPY REPRESENTATIVE DATE

NOTICE OF APPOINTMENT TIMES:

Dear Valued Patient:

We appreciate your trust in choosing Southern Therapy Services, Inc. for your rehabilitation needs. Our desire is for your time with us to be “Gold Standard” in every way. We bring state-of-the-art care in a comfortable and education oriented setting and are committed to providing the highest quality rehabilitation services possible.

Healthcare providers are notorious for making patients wait; Southern Therapy Services is the exception. Our goal is to see all patients at their appointed time (no more than 10 minutes beyond this). We ask for your assistance in reaching this goal by observing the following points:

- Your scheduled appointment time is reserved for you on your therapist’s schedule. If you are running late, please contact our office and establish that we can still keep the appointment or if it is best to reschedule.

- We strive to keep your check-in time at a minimal. On your first visit, please arrive 20 minutes prior to your scheduled visit in order to fill out the required paperwork.

- We realize situations occur that make cancelling an appointment necessary. Please call us at your earliest convenience if you know you must reschedule.

- Our therapists reserve one half hour to one hour per patient. If someone fails to show up to their scheduled appointment without prior notification, our therapists are not able to schedule someone else in your place.

We are honored to serve you and sincerely appreciate each of our patients. If we can assist in any way, do not hesitate to ask.

CARROLLTON
812 South Park Street
770-834-7436

BREMEN
204 Allen Memorial Drive, STE 301
770-537-6477

VILLA RICA
690 Dallas HWY, STE 203
770-459-4555

Client Name: _____

Date: _____

Case #: _____

FYZICAL® Therapy & Balance Centers

Southern Therapy Services, Inc.

Client Needs Screen (CNS)

1. Have you had a fall in the past year?	☐ Yes ☐ No
2. Do you have a fear of falling?	☐ Yes ☐ No
3. Would you like your balance to be assessed?	☐ Yes ☐ No
4. Do you experience dizziness or imbalance?	☐ Yes ☐ No
5. Do you lose your balance when stepping up/down curbs or stairs/steps?	☐ Yes ☐ No
6. Do you have a difficult time walking in the dark?	☐ Yes ☐ No
7. Do you have difficulty hearing?	☐ Yes ☐ No

8. Do you have osteoporosis, osteoarthritis and/or joint pain?	☐ Yes ☐ No
9. Do you take bone and/or joint supplements?	☐ Yes ☐ No
10. Do you experience muscle aches, pains and/or muscle cramping?	☐ Yes ☐ No
11. Do you use cold, heat or compression therapy at home?	☐ Yes ☐ No
12. Are you interested in learning how compression clothing with ice could help your condition?	☐ Yes ☐ No
13. Are you interested in learning how home heat and/or cold therapy could help your condition?	☐ Yes ☐ No

14. Do you have foot and/or ankle pain/discomfort?	☐ Yes ☐ No
15. Are you interested in weight loss or Nutrition Counseling?	☐ Yes ☐ No
16. Are you interested in learning about how a shoe insert could help your condition?	☐ Yes ☐ No
17. Do you have pain and/or physical challenges other than what you are being seen for today?	☐ Yes ☐ No
18. Would you like to get more information about your whole body health?	☐ Yes ☐ No
19. Are you interested in learning how a medically based fitness program could safely optimize your physical condition?	☐ Yes ☐ No