To Reschedule or Cancel call 770-834-7436

SOUTHERN THERAPY SERVICES, INC.
PATIENT INFORMATION

STS USE ONLY

THERAPIST	
DIAGNOSIS	
ANATOMY	

DATE: ____________________ **APPOINTMENT TIME:** ____________________

**** PLEASE COMPLETE ALL INFORMATION ON THIS FORM AND SIGN BELOW. ****

Patient Name: (Last)______________________________(First)____________________(Middle)_______

Mailing Address________________________________City________________State_____Zip________

Home Phone ( )____________________ **Date of Birth:**_______/_______/_______Age_______

Cell Phone ( )____________________ Email____

SS# ________/________/________ **Sex**: Male Female **Marital Status**: S M W D

Patient/Parent Employer____________________Occupation________________Phone____________

Employer Address______________________________City________________State_____Zip________

Spouse/Parent Name______________________________________ SS#______/______/______

Spouse/Parent Employer____________________________________ Phone________________

In case of Emergency / Not Living With You__________________Relation______________Phone____________

Person Responsible For Account______________________Relation________________Phone____________

Have you been seen at Southern Therapy before? YES / NO When?____________________

Have you received previous therapy any this year? YES / NO When?____________________

Referring Physician Name______________________________ Date Last Seen?______________

**** PLEASE PRESENT COPIES OF CURRENT INSURANCE CARDS TO FRONT DESK ****

CIRCLE INSURANCE TYPE: AUTO MEDICARE WORKER'S COMP. REGULAR INS. CASH

ARE YOU ELIGIBLE FOR MEDICARE BENEFITS? Circle YES NO As PRIMARY or As SECONDARY

INSURANCE NAME: ______________________________ CUSTOMER SERVICE PHONE: ____________________

INSURED NAMED: ______________________________ MEDICAL PROBLEM: ____________________

SOCIAL SECURITY # OF INSURED: ______________________ RELATIONSHIP TO INSURED: ____________________

INSURED's DOB: ______________________________ EMPLOYER NAME: ____________________

POLICY # / MEDICARE # ______________________________ GROUP # ____________________

EMPLOYER / W/C PHONE: ______________________________ EMPLOYER/ W/C CONTACT: ____________________

DATE OF INJURY: ______________________________ CLAIM W/C #: ____________________

The statements are true and complete to the best of my knowledge. I understand fully 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 I am financially responsible to Southern Therapy Services, Inc., for charges not covered by my insurance company. I understand my physician has referred me to physical therapy and hereby agree to the treatment and/or test procedures felt necessary by my physician and physical 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'S SIGNATURE ____________________ DATE

____ IF MINOR, PARENT'S SIGNATURE ____________________ DATE

SUBJECTIVE MEDICAL HISTORY

Name: ______________________________ Date: ______________
Physician(s): ______________________________

What type of problem(s) are you having at the present time? ______________
Rate severity of pain 0-10(10 being the worst) **0 1 2 3 4 5 6 7 8 9 10**
Are your symptoms **worse**, **better**, or **the same** as they were initially? (Circle one)
Describe the location and type of pain: ______________
When did the symptoms start? ______________
If injury, how did you hurt yourself? ______________
Have you had this before? YES________ NO________
If yes, When? ______________
Do you or have you had problems with any of the following? (Circle all that apply)
HEART, HIGH BLOOD PRESSURE, DIABETES, BACK PROBLEMS, CANCER, NECK PROBLEMS, CURRENT INFECTIOUS DIEASE, AND SURGERY

Did the injury occur at work? YES________ NO________
Describe injury: ______________

____

Are you presently working? YES________ NO________
Job Title: ______________
Job Restrictions: (From Doctor) ______________

Do you exercise? YES________ NO________
What activity? ______________

Any Hobbies? Describe______________

____

What can't you do because of this problem? ______________

What activities increase your pain? ______________

What activities decrease your pain? ______________

What is your height______________ what is your weight______________

FINANCIAL POLICY

We are doing everything possible to keep the cost of medical care down. 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, VISA, and MasterCard. 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.

If you have a change in your insurance company during the course of your treatment, it is your responsibility to get the updated information to our staff as quickly as possible. Any updates not received that results in the denial of your claims will become your responsibility to pay.

Southern Therapy Services, Inc. does not accept attorney liens or bill third party insurance companies.

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. If you do not have a supplemental policy, you are responsible for any percentages due according to our contractual Medicare fee schedule.

PATIENT CREDIT:

Southern Therapy Services strives to accurately collect insurance co-pays, deductibles and percentages correctly the first time, however, due to the numerous insurance plans and specifications there may be times where you will 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 a patient credit is due, an acknowledgment will be mailed to the address on the account for you to sign and return. Please allow a maximum of 30 days for refund to be processed.

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 do not charge for appointments cancelled where 24 hours notice has been given, however we reserve the right to charge $25.00 for missed or late-cancelled appointments. Three missed scheduled appointments will result in discharge from treatment.

PRIVACY NOTICE INFORMATION

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.'s 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 Acknowledgement of receipt, the patient or representative refused to sign or was unable to sign the Privacy Notice for the following reason(s) _______________________________

____

_______________________________ _______________

Southern Therapy Services, Inc. Representative Date

PATIENT RESPONSIBILITIES

Southern Therapy Services, Inc. strives to excel in patient satisfaction and we want your first visit and all your visits to be the most pleasant experience possible with the shortest amount of wait time. We appreciate your commitment to: arrive on time; make payments as expected; complete home exercise programs; refer family and friends; and to let us know how we can better serve you.

The following information should assist you with any questions:

First Visit: **We ask that you arrive 20 minutes before your appointment time**. This is to allow time for you to fill out any necessary paperwork, for us to answer any questions you may have regarding your insurance benefits, and for us to obtain any additional information we may need from you. Please bring back any paperwork we may have already given you to fill out. We will need a copy of your insurance card in order for us to properly inform your insurance company that you will be receiving therapy. **For your first visit,** we MUST have the doctor's order/prescription. *If you do not have it with you on your first visit, we will have to reschedule your appointment for a later time.* Your doctor's office may fax the order to us any time prior to your appointment.

Insurance: **All co-pays and percentages are due at the time services are rendered.** For your convenience, we gladly accept cash, check, or credit card. Please let us know if you have any questions regarding your financial responsibility. 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***. You will receive our company Financial Policy on your first visit; please let us know if you have any questions. All accounts must be settled promptly.

Scheduling: For your regular visits, please arrive a few minutes early; sign in upon arrival, and feel free to check at the front desk if you have been waiting for over 15 minutes from our appointment time. When you leave, be sure you have scheduled your next appointment and have checked out at the desk to pay any balances you may have with us.

Cancellation: As a benefit to you, we ask that our patients keep all scheduled appointments. ***Please be aware that three consecutive missed appointments will result in a discharge.*** We do not charge for appointments cancelled where 24 hours notice has been given, however we reserve the right to charge $25.00 for missed or late-cancelled appointments.

Therapist: You will be assigned a highly qualified and trained team of therapists to help in your recovery.

Attire: You will want to wear comfortable clothing that allows you to move freely and that allows the therapist to gain access to the body part being treated. For example, a knee patient should wear shorts so their knee is exposed and accessible to the therapist.

Parking: Convenient parking is located in close proximity to our facility. Handicap parking and 5 minute patient drop-off is available for your convenience.

Thank you for choosing Southern Therapy Services, Inc. for your therapy needs. If you have any questions, please feel free to call us at 770-834-7436 or visit our website www.southerntherapyservices.com

Name:________________________E-mail:_____________________Phone #:__________________

SOUTHERN THERAPY SERVICES, INC
SUPPLEMENT SURVEY

1) Are you taking any nutritional supplements? ______Yes ______No

2) If so, what are you presently taking? ______Glucosamine ______Calcium
______ Fish Oil ______ Multi-Vitamin
______ Other: ________________________________

3) Who recommended you to take these supplements?

______Family member or Friend
______Health Professional
______Advertisement
______Other:________________________

4) Where did you purchase these supplements?

______Mail Order
______Nutrition or Vitamin Store
______Pharmacy
______Healthcare Provider
______Other:________________________

5) If your Healthcare Professional offered an advanced, high quality line of supplements tailored to your specific needs, would you consider purchasing them?

______Yes ______No

6) Can you take anti-inflammatory medication? (i.e. - Advil, Naproxen, Motrin, Etc..)

______Yes ______No

7) If this office offered a comprehensive Wellness/weight management program, would you consider it?

______Yes ______No

8) If this clinic offered a nutrition education program to improve your overall health, would you consider it?

______Yes ______No