



**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/FYZICAL 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: \_\_\_\_\_

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

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/FYZICAL. I hereby authorize Southern Therapy Services/FYZICAL 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/FYZICAL 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/FYZICAL 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 SERVICES/FYZICAL 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/FYZICAL 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/FYZICAL 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/FYZICAL 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 Southern Therapy/FYZICAL, 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/FYZICAL 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/FYZICAL Privacy Notice.

**COLLECTION POLICY:**

Southern Therapy/FYZICAL strives to assist all patients in meeting their financial obligation prior to enlisting the assistance of a collection agency. Third-party debt collection agencies will be enlisted only after all reasonable collection and payment options have been exhausted. Agencies may help resolve accounts for services where patients are uncooperative in making payments, have not made appropriate payments, or have been unwilling to provide reasonable financial and other data to support their request for charity care.

Collection agency staff will uphold the confidentiality and individual dignity of each patient.

In the event my account becomes past due and is referred to an outside collection agency or attorney, I will be responsible for the collection costs at the rate of 27% of the balance due, in addition to the amount owed.

I have read and understood the Southern Therapy Services/FYZICAL Financial Policy. I agree to assign insurance benefits to Southern Therapy Services/FYZICAL.

\_\_\_\_\_  
**Signature of Patient/Responsible Party**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Southern Therapy/FYZICAL Representative**

\_\_\_\_\_  
**Date**

-----  
*Only to be completed by Southern Therapy Services/FYZICAL:*

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/FYZICAL REPRESENTATIVE

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
DATE

## **NOTICE OF APPOINTMENT TIMES:**

Dear Valued Patient:

We appreciate your trust in choosing Southern Therapy Services/FYZICAL 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/FYZICAL 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**

300 Alabama Avenue  
770-537-6477

### **VILLA RICA**

214 Maple Street  
770-459-4555

Client Name: \_\_\_\_\_

Date: \_\_\_\_\_

Case #: \_\_\_\_\_



### Client Needs Screen (CNS)

✱ 1. Have you had a fall in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
✱ 2. Do you have a fear of falling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
✱ 3. Would you like your balance to be assessed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
✱ 4. Do you experience dizziness or imbalance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
✱ 5. Do you lose your balance when stepping up/down curbs or stairs/steps?	<input type="checkbox"/> Yes <input type="checkbox"/> No
✱ 6. Do you have a difficult time walking in the dark?	<input type="checkbox"/> Yes <input type="checkbox"/> No
✱ 7. Do you have difficulty hearing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
✱ 8. Do you have osteoporosis, osteoarthritis and/or joint pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
✱ 9. Do you take bone and/or joint supplements?	<input type="checkbox"/> Yes <input type="checkbox"/> No
✱ 10. Do you experience muscle aches, pains and/or muscle cramping?	<input type="checkbox"/> Yes <input type="checkbox"/> No
✱ 11. Do you use cold, heat or compression therapy at home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
✱ 12. Are you interested in learning how compression clothing with ice could help your condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
✱ 13. Are you interested in learning how home heat and/or cold therapy could help your condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
✱ 14. Do you have foot and/or ankle pain/discomfort?	<input type="checkbox"/> Yes <input type="checkbox"/> No
✱ 15. Are you interested in weight loss or Nutrition Counseling?	<input type="checkbox"/> Yes <input type="checkbox"/> No
✱ 16. Are you interested in learning about how a shoe insert could help your condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
✱ 17. Do you have pain and/or physical challenges other than what you are being seen for today?	<input type="checkbox"/> Yes <input type="checkbox"/> No
✱ 18. Would you like to get more information about your whole body health?	<input type="checkbox"/> Yes <input type="checkbox"/> No
✱ 19. Are you interested in learning how a medically based fitness program could safely optimize your physical condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No