Southern Therapy Advanced Rehabilitation for Kids
Southern Therapy Services, Inc.
Patient Information

STS USE ONLY

Therapist	
Diagnosis	
Anatomy	

Date: _____
Appointment Time: _____
Patient Name: (Last) _____ (First) _____ (Middle) _____
Mailing Address: _____ City _____ State ____ Zip _____
Home Phone: ( )_____ Cell Phone: ( )_____ Date of Birth: ___/___/___ Age: ____
SS#: ____/____/____ Gender: Male Female
Parent Name: _____ SS#: ____/____/____
Parent Employer: _____ Occupation: _____ Work Phone: _____
Employer Address: _____ City _____ State_____ Zip _____
Nearest Relative Not Living With You: _____ Phone: _____
Person Responsible for Account: _____ Relation: _____ Phone: _____
Have you been seen by Southern Therapy before? YES NO When? _____
Referring Physician's Name _____ Date last seen by MD? _____
Date of Injury: _____ How did you learn of our clinic? _____

**** PLEASE PRESENT INSURANCE CARD AND ORDER TO THE FRONT DESK****

TYPE OF INSURANCE: MANAGED CARE MEDICAID AMERIGROUP PEACH STATE WELLCARE

Insurance Name: _____
Insured Name: _____
SS# of Insured: _____
Relation: _____
Customer Service Phone: _____
PT: _____ OT: _____ Both: _____

Policy Number: _____
Group Number: _____
Medicaid Number: _____
Name of Primary Care Physician: _____
Reason for Therapy: _____

These 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 assign the 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 therapy and hereby agree to the treatment and/or test procedures felt necessary by my physician and therapist. **I certify by signature that I have read and agree to this policy.** A photographic copy of this authorization will be considered as effective and valid as the original.

_____ _____
Patient's Signature Date

_____ _____
If Minor, Parent/Guardian Signature Date

Subjective Medical History

Name: _____ Date of Birth: _____
Physician(s): _____
Parent/Guardian: _____

What are your main concerns? _____
_____

Does your child have a diagnosis? _____

List all members residing in household, age, and relationship _____
_____

List the school and grade (if applicable): _____
Teacher: _____
Does your child receive school services? _____

Is your child on any medication? _____

Where there any pregnancy complications? _____
_____

Has your child ever been hospitalized? List dates, hospital, and reason for hospitalization _____
_____

Has your child received physical, occupational, or speech therapy before? _____

Does your child have any difficulties eating or gaining weight? _____
_____

How old was your child when he/she first:

Held head up _____
Held toy _____
Sat independently _____
Crawled _____
Walked _____

Rolled stomach to back _____
Supported weight on legs _____
Rolled back to stomach _____
Pulled self to standing _____
Jumped _____

Is there anything about your child and/or family you would like us to know? _____
_____
_____
_____
_____

What are your goals for your child? _____
_____
_____
_____
_____

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

BY SIGNIGNG BELOW, I HEREBY ACKNOWLEDGE RECEIPT OF SOUTHERN THERAPY SERVICES, INC. PRIVACY NOTICE.

Printed Name of Patient	Date
Signature of Patient or Parent/Guardian	Date
Printed Name of Parent/Guardian	Date

To be completed by Southern Therapy Services, Inc.:

After a good faith attempt to obtain an Acknowledgement of receipt, the patient or parent/guardian refused to sign or was unable to sign the Privacy Notice for the following reason(s) _____

_____

_____

Signature of Southern Therapy Services, Inc. Representative	Date