PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, SHORELINE PHYSICAL THERAPY may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to SHORELINE PHYSICAL THERAPY'S notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. SHORELINE PHYSICAL THERAPY reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to SHORELINE PHYSICAL THERAPY, Privacy Officer, at 1717 Shipyard Blvd., Suite 320, Wilmington, NC 28403.

With my consent, SHORELINE PHYSICAL THERAPY may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist in the practice of carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care.

With my consent, SHORELINE PHYSICAL THERAPY may email to me appointment reminder cards and patient statements. I have the right to request that SHORELINE PHYSICAL THERAPY restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but, if it does, it is bound by this agreement.

By signing this form, I am consenting to SHORELINE PHYSICAL THERAPY the use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, SHORELINE PHYSICAL THERAPY may decline to provide treatment to me.

____ ____________________

Signature of Patient or Legal Guardian Date

____

Patient's Name

____

Printed Name of Patient or Legal Guardian

1717 Shipyard Blvd., Suite 320
Wilmington, NC 28403
Phone (910) 791-0396
Fax (910) 791-0818
Email: Shorelinept@gmail.com

Douglas A. Miller, PT, MSPT, SCS, Cert. MDT
Jerome A. "Jai" Isear, Jr., MS, PT, LAT, ATC
Stephen L. Bright Jr., LAT, ATC, Cert. MDT
Susanne L. Butler, PT

Patient's Name: Last ______________________________ First __________________________ Middle Intitial ___

☐ Male ☐ Female Age:__________

Birthdate:________________ SSN:___________________

Address:____

City, State, Zip:__________________________________

Home Phone: (______)__________-____________

Work Phone: (______)__________-____________

Cell Phone: (______)__________-____________

Email:_______________________________________

Emergency Contact:______________________________

Relation:____

Phone: (______)_________-__________

Referred by:______________________________________

Are you employed? ☐Yes ☐No How Long?_________

Occupation:______________________________________

☐ Full Time ☐ Part Time

Employer:____

Employer Address:_________________________________

City, State, Zip:___________________________________

Employer Phone: (______)________-_____________

Date of Injury:_____________________________________

☐ Married ☐ Single ☐ Divorced

Spouse's Name:____________________________________

Spouse's Employer:_________________________________

Are you a student? ☐ Yes ☐ No

School:____

PRIMARY INSURANCE / WORKER'S COMP

Carrier Name:____

Address to mail claim:

____

____

____

Phone: (______)_________-____________

Policy # or Case #:____________________________________

Group #:____

Policy Holder's Name:__________________________________

Policy Holder's Birth Date:______________________________

Patient's Relationship to Policy Holder:

☐ Self ☐ Dependent ☐ Spouse ☐ Child

☐ Other:____

SECONDARY INSURANCE

Carrier Name:____

Address to mail claim:

____

____

____

Phone: (______)_________-____________

Policy # or Case #:____________________________________

Group #:____

Policy Holder's Name:__________________________________

Policy Holder's Birth Date:______________________________

Patient's Relationship to Policy Holder:

☐ Self ☐ Dependent ☐ Spouse ☐ Child

☐ Other:____

Please give your insurance cards to the receptionist so that a copy can be made for our records. Thanks.

RESPONSIBLE PARTY (RP) INFORMATION

RP Name: ____
Address: ____
City, State, Zip______________________________________
Home Phone: (________)__________-____________________
SSN: _________________________ Birth Date: ______________

RP Occupation: ______________________________________
Employer: ____
Address: ____
City, State, Zip: ______________________________________
Work Phone: (_______)___________-____________________

REASON FOR THERAPY: ____

Onset Date of Injury or Symptoms: _____________________________________

Insurance Assignment:

I, the undersigned, having insurance coverage, authorize assignment of all medical benefits, if any, directly to Shoreline Physical Therapy. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the staff at Shoreline Physical Therapy to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submission whether manual or electronic.

____ ____________________

Signature of Insured or Guardian Date

Medicare Authorization:

I request that payment of authorized Medicare benefits be made on my behalf to Shoreline Physical Therapy for any services furnished to me by them. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA 1500 form or elsewhere on the other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned claims, Shoreline Physical Therapy agrees to accept the charge determination of the Medicare carrier as the full charge, and I am responsible for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

____ ____________________

Beneficiary Signature Date

Authorization to Receive Therapy:

I hereby authorize treatment to be rendered by Shoreline Physical Therapy as prescribed by my physician.

____ ____________________

Signature & Release for Treatment Date
(If minor, Guardian signature)

Appointment Policy

To help us provide quality care to all of our patients, we kindly ask that you comply with the following policy:

- If you cannot keep your scheduled appointment, please call us as soon as possible to re-schedule or cancel. Multiple and consecutive cancellations may lead to your discharge from physical therapy.
- If you are late for your scheduled appointment, it will be left to the discretion of management as to whether or not you can be seen.
- Missing your scheduled appointment without notifying the physical therapy staff in advance is considered a "No Show." If this occurs more than twice, you may be discharged from physical therapy.

It is our intention to provide you with the highest quality physical therapy services possible, and your cooperation and compliance with our attendance policy is important. Your signature below indicates that you have read the above policy and agree to abide by it. Thank you.

____________________________________ _______________

Patient's Signature Date

1717 Shipyard Blvd., Suite 320, Wilmington, NC 28403 ◆ PH 910-791-0396 ◆ FAX 910-791-0818

Authorization to Disclose Personal Health Information

Patient Name: ____

Date of Birth: ____

Names of persons eligible to receive information on my behalf:

____________________________________ Relation ____________________

____________________________________ Relation ____________________

____________________________________ Relation ____________________

____________________________________ Relation ____________________

COMPLETE ONLY IF LIMITED INFORMATION

□ Information about Insurance only

□ Information about Services Rendered only

□ Information about Account Balance/Bills only

CHECK BOX INDICATING HOW LONG AUTHORIZATION IS VALID:

□ Disclose my personal health information indefinitely

□ Disclose my personal health information for a specified period only, beginning (mm/dd/yy) ______________ and ending (mm/dd/yy) ______________.

____ ______________

Authorized Signature Date