New West Orthopaedic & Sports Rehabilitation, LLC.

DATE:__________

Patient's Name: ____Social Security #:_________________
Patient's street address:_______________________________________Home Phone: (___)________________
Patient's mailing address: ______________________________________ Cell Phone: (___)________________
City: ______________State: _______Zip: ___________________
Date of Birth: ___________Age______Sex___Marital Status___(S)Single (M)Married (D)Divorced (W)Widowed
Patient's Employer: ____Work Phone#:(___)_____________
Employer's Address: ____City/State/Zip__________________
Spouse or Parent's name: _______________________________________Phone Number #:(___)_____________
Spouse or Parent's address: ____________________________________City/State/Zip____________________

Person to notify in case of Emergency____
Relationship____________________________________ **Phone**________________________

Referring Doctor_______________________________________City/State_____________________________
Family Doctor____ City/State_____________________________

WAS THIS A CAR ACCIDENT OR AN INJURY? NO___YES____ACCIDENT/INJURY DATE: ___________

(We must have DATE if accident/injury)

If ***YES***, **please circle the type of accident/injury: Workers Compensation Sports Motor Vehicle Other**________________

INSURANCE INFO MUST BE COMPLETELY FILLED OUT IF YOU DO NOT HAVE A CARD FOR US TO COPY

(Please present insurance cards to receptionist) **We must have the employer information for Insurance purposes.**

PRIMARY INSURANCE NAME__________________________Group Name________________________
Insurance Address___________________________________ City/State___________________Zip_______
NAME OF INSURED___________________________________POLICY #__________________________
INSURED'S EMPLOYER_______________________________ GROUP #__________________________
Patient relationship to insured Self Spouse Child

SECONDARY INSURANCE NAME______________________Group Name________________________
Insurance Address___________________________________ City/State___________________Zip_______
NAME OF INSURED___________________________________POLICY #__________________________
INSURED'S EMPLOYER_______________________________ GROUP #__________________________
Patient relationship to insured Self Spouse Child

IF THIS IS A WORKER'S COMPENSATION CLAIM, WHERE DO WE SEND BILLS:
Company's Name: ____Claim#:____________________
Address:____City/State/Zip: _________________
Phone #: (___)_________________________________Case Manager:_______________________________

Complete This Section if Patient is Under 19 and/or a Full-Time College Student

Mother's Name: _________________________________ Father's Name:_______________________________
Mother's Address: _______________________________Mother's Address: ____________________________
City/State/Zip: _________________________________City/State/Zip: _______________________________
Mother's Home Phone #: (___)_____________________Father's Home Phone #: (___)____________________
Mother's Alternate Phone #: (___)_________________ Father's Alternate Phone #: (___)________________
Mother's Employer: ______________________________ Father's Employer: ____________________________
Employer's Address: _____________________________Employer's Address: ___________________________
Employer's Phone #: _____________________________Employer's Phone #: ___________________________
Guarantor of This Account: Yes _______ No _________ Guarantor of This Account: Yes _______ No ______

Parent or Legal Guardian Please Complete if Patient is Under the Age of 19:
The above named patient has a condition requiring diagnosis and treatment and I hereby consent to such diagnostic procedures and treatment as judged necessary by the physical therapists of New West Orthopaedic and Sports Rehabilitation, L.L.C.

____ Date: _______________Relationship: ____________________
Signature of Legally Responsible Representative

NEW WEST ORTHOPAEDIC & SPORTS REHABILITATION, LLC
Medical History

NAME: ____AGE:_____DOB:__________ Male/Female______________

OCCUPATION:____HEIGHT:______________WEIGHT:______________

FAMILY PHYSICIAN:_______________________________________REFERRED BY:__________________________________

PLEASE DESCRIBE THE PROBLEM YOU ARE BEING SEEN FOR TODAY:____
____

IS THIS PROBLEM WORK RELATED?____________________________ WHEN DID PROBLEM BEGIN?________________

HAVE YOU HAD ANY OTHER THERAPY FOR THIS PROBLEM?____

PLEASE LIST **ALL MEDICATIONS** THAT YOU ARE CURRENTLY TAKING:

___________________________ _________________________ ____________________________ _____________________

___________________________ _________________________ ____________________________ _____________________

LIST **ALL ALLERGIES:** ____

ARE YOU ALLERGIC TO LATEX? YES_______NO _______

LIST ALL PAST SURGERIES (DATES IF KNOWN):

___________________________ _________________________ ____________________________ _____________________

___________________________ _________________________ ____________________________ _____________________

HAVE YOU HAD OR DO YOU PRESENTLY SUFFER FROM:

Condition	Response	Condition	Response
Anemia	Yes__No__	Hepatitis	Yes__No__
Angina, Heart Problem, Pacemaker	Yes__No__	Tuberculosis	Yes__No__
Arthritis	Yes__No__	Blood Transfusion	Yes__No__
Asthma	Yes__No__	Ulcer/Stomach Bleeding/Indigestion	Yes__No__
Cancer/Tumor	Yes__No__	Thyroid Disorder	Yes__No__
Diabetes	Yes__No__	Depression or Anxiety	Yes__No__
Emphysema/Chronic Bronchitis	Yes__No__	Chemical Dependency/Alcoholism	Yes__No__
Hearing Loss	Yes__No__	Blood Clots/Phlebitis	Yes__No__
Heart Valve Problems	Yes__No__	Bleeding Disorder Tendency	Yes__No__
High Blood Pressure	Yes__No__	Difficulty Voiding	Yes__No__
Irregular Heartbeat	Yes__No__	Kidney Bladder Infection	Yes__No__
Night Sweats/Weight Gain/Loss	Yes__No__	Reaction to General/Local Anesthesia	Yes__No__
Osteoporosis	Yes__No__	Psoriasis/Skin Rash	Yes__No__
Seizures/Stroke	Yes__No__	Elevated Cholesterol	Yes__No__
Vision loss or Glaucoma	Yes__No__	Pneumonia	Yes__No__

List Any Other Medical Problems Not Mentioned Above: ____

Have you had Cortisone? Yes______No_______ Injections or Pills?____

Tobacco Use? Yes______No ______ How Often?_________ Caffeine Use?Yes______No ______ How Often?__________

List any additional information that you feel would be important to your treatment: _____________________________
____

Signature:____ **Date:**________________________

New West Orthopaedic & Sports Rehabilitation, LLC
3219 Central Avenue Suite 104
Kearney, NE 68847
308.237.7388

We are committed to providing you with the best possible treatment. In order to achieve this goal, we need your assistance and understanding of our financial policies. If you have any questions concerning our policies, please contact our billing staff.

Health Insurance

We will be happy to file medical insurance claims for you. In order to do so, you must present your insurance card at the time of registration.

Covered benefits vary between insurance plans. Some insurance plans require pre-authorization for therapy services. Therefore, make sure you have pre-authorized your treatment(s), if necessary. Additionally, it is your responsibility to understand the limitations and exclusions of your policy. If you have any questions regarding your coverage, please contact your plan administrator or the insurance company's customer service department.

You will be responsible for payment of non-covered services, deductible and co-insurance amounts. Please refer to the self-payment policy for additional information regarding payment arrangements. If your insurance policy requires a co-payment for each visit, it must be paid at the time of your visit.

Workers Compensation

Our policy is to file worker's compensation claims on behalf of our injured patient. However, if a denial is received from the worker's compensation insurance company or if your claim is not settled within six months, we require that you begin making regular monthly payments. Failure to make regular payments may result in your account being turned over to a collection agency. We can also submit to your health insurance for payment at your request as long as the information is provided to us. We will work with you to establish a reasonable monthly or weekly payment plan to accommodate your needs. If an attorney is involved, we will file a lien with them, but this in no way releases your responsibility in making the required monthly payments. ___________

Liability Claims

Our policy is to file liability claims on behalf of our injured patients. However, if a denial is received or if your claim is not settled within six months, we will ask that you begin making regular monthly payments. Failure to make regular monthly payments may result in your account being turned over to a collection agency. We can also submit to your health insurance for payment at your request as long as the information is provided to us. We will work with you to establish a reasonable monthly or weekly payment plan to accommodate your needs. If an attorney is involved, we will file a lien with them, but this in no way releases your responsibility in making the required monthly payments. ___________

Medicare

Medicare will cover most therapy charges provided that you have a referral from your doctor. You will receive a bill from us only after Medicare has paid. If you have a Medicare supplemental policy, we will file those claims provided that you have supplied us with the required information.

Medicaid

As a participating Medicaid provider, we will file claims to the Nebraska Department of Health & Human Services. Effective April 1, 1994, some Medicaid recipients are required to pay a co-payment for each visit. The Department of Health & Human Services requires that this co-payment be made at the time of each treatment and will not allow us to waive co-payment. Please make this payment to the receptionist upon arrival.

Self Payment Accounts

We ask that you remit payment within ten days of receiving your monthly statement. We are happy to accept payments by cash, check or credit card. (MasterCard & Visa) If your account reaches 90 days past due and you have not contacted us to make a payment arrangement, your account may be turned over to our collection agency.

______________________________________ ______________________________

Patient's Signature or Authorized Representative Date

New West Orthopaedic & Sports Rehabilitation, L.L.C.

PATIENT NAME: ____

RELEASE OF INFORMATION AND GUARANTEE OF PAYMENT

1. Release of information – I hereby authorize New West Orthopaedic & Sports Rehabilitation, L.L.C., to release any and all of my/the patient's medical records verbally, via facsimile, via photocopying, or via on site review to other health care institutions to whose care I may be transferred or am being evaluated for transfer to, and agencies or physicians that may become involved in further treatment or follow-up care, to my/the patient's insurance or third party payor, for utilization review purposes and for the purpose of New West Orthopaedic & Sports Rehabilitation, L.L.C. to release my/the patient's general status information to relatives and friends.

2. Medicare/Medicaid Authorization – I, whether signing as patient or agent, hereby authorize New West Orthopaedic & Sports Rehabilitation, L.L.C. to release to Medicare and/or Medicaid, to the Social Security Administration and/or its intermediaries or carriers, to any peer review organization, or any state agency from which I/the patient am entitled to payment for medical benefits any information needed for this or a related Medicare and/or Medicaid claim. I certify that the information given by me in applying for payment under 1111 Title XVIII and Title XIX of the Social Security Act is correct.

3. Assignment of benefits and authorization to bill – I, whether signing as patient or agent, authorize billing by and direct payment to New West Orthopaedic & Sports Rehabilitation, L.L.C. of any insurance benefits (as defined below) and any governmental program benefits otherwise payable to or on behalf of me or the patient for these services, including emergency services if rendered, at a rate not to exceed New West Orthopaedic & Rehabilitation's regular charges. The term "insurance benefits": as used in herein includes all insurance benefits including but not limited to health insurance, accident, casualty insurance, medical payments coverage and uninsured or underinsured insurance. It is understood by the undersigned that he/she is financially responsible for the charges not covered by this agreement. In consideration of goods and services provided, the undersigned gives New West Orthopaedic & Rehabilitation, L.L.C., irrevocable assignment to any and all rights, title and interest he/she has in all insurance benefits or governmental program benefits payable to him/her or on his/her behalf for services provided by New West Orthopaedic & Sports Rehabilitation, L.L.C. I direct all insurance companies, health plans, governmental agencies and their agents or contractors, and attorneys to make such payment directly to New West Orthopaedic & Rehabilitation, L.L.C.

4. Guarantee of payment – For good and valuable consideration of services to be rendered to me/the patient identified on this sheet, I hereby guarantee payment of the entire medical bill expense incurred at New West Orthopaedic & Sports Rehabilitation, L.L.C.

MY SIGNATURE BELOW INDICATES THAT THIS INFORMATION HAS BEEN EXPLAINED TO ME. I HAVE READ THIS FORM OR IT HAS BEEN READ TO ME. I UNDERSTAND THIS AGREEMENT FULLY.

______________________________	______________________________
Signature of Patient	Date
______________________________	______________________________
Signature of Parent/Guardian	Witness

I have reviewed this privacy practices form and herby acknowledge that I have read and understand the privacy practices of New West Orthopaedic & Sports Rehabilitation.

____

Name of Patient (Print Please)

X____

Signature of Patient

____

Date

____

Signature of Patient Representative

____

Relationship of Patient Representative to Patient

By this form I give permission to New West Orthopaedic & Sports Rehabilitation, to discuss my medical condition with the following people.

Name of Person(s)

Spouse:____

Children:____

Other Family Members:____

Caregivers:____

Guardian:____

Close Personal Friends:____

____

Name of Patient Date of Birth

X____

Signature of Patient

____

Date

____

Personal Representative

HIPAA NOTICE OF PRIVACY PRACTICES

New West Orthopaedic & Sports Rehabilitation, LLC
3219 Central Avenue, Suite 104
Kearney, Nebraska 68847
(308) 237-7388

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMAITON. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physical therapist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to your, to pay your health care bills, to support the operation of the physical therapist’s practice and any other uses required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Options: We may use or disclose, as needed, your protected health information in order to support the business activities of your physical therapist’s practice. The activities include, but are not limited to quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physical therapist is ready to see you. We may use or disclose your protected health information, as necessary, to contact your to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include; as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, Authorization or Opportunity to Object unless required by law.

You may revoke this Authorization at any time, in writing, except to the extent that your physician or the physician’s practice has taken an action in reliance on the use or disclosure indicated in the authorization.

<u>Your Rights</u>
Following is a statement of your rights with respect to your protected health information.

<u>You have the right to inspect and copy your protected health information.</u> Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

<u>Your have the right to request a restriction of your protected health information.</u> This means you may ask us not to use or disclose any part of your protected health information that is subject to law that prohibits access to protected health information.

<u>You have the right to request a restriction of your protected health information.</u> This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected heath information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

<u>You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,</u> upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

<u>You have the right to have you physician amend your protected health information.</u> If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

<u>You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.</u>

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

<u>Complaints</u>
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact o your complaint. **<u>We will not retaliate against you for filing a complaint.</u>**

This notice was published and becomes effective on or before **<u>April 14, 2003</u>**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

____
Print Name

____
Signature

____
Date