Landers Physical Therapy
New Patient Form

Date:_______________________

Name: (First)__________________ (M.I.)______ (Last)_________________________________

Mailing Address:____

City______________________________ State______________________ Zip______________

Phone:_________________(Home,Mobile,Work) Phone:_________________(Home,Mobile,Work)

Email Address:____

Social Security Number:____________________ Date of Birth:_________ Age:______ Sex: M / F

Emergency Contact:______________________________ Telephone:_______________________

Do you Currently or have you recently had Home Healthcare Services? Yes / No

How did you hear about us? (other than referring Physician)__________________________________

Referring Physician:_________________________ Next Appointment: ______________________

Status: Married / Single / Divorced / Separated / Widowed

Employment: Full-Time / Part-Time / None / Retired

Employer___________________________________ Phone_______________________________

Injury Type: □ Work □ Auto □ Home □ Other___________________ Date of Injury:___________

If Work Comp Claim: Employer at time of Injury:___________________ Phone:________________

Attorney Involved? Yes / No Attorney's Name:____________________ Phone:________________

Insurance Policy Holder: Name:__________________ DOB__________ SS#:______________

Patient Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care at the lowest possible cost. Please understand that payment of your bill is considered a part of your treatment. We need your assistance, and your understanding of our payment policy. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

- We will file your insurance as a courtesy
  Primary:______________________________
  Secondary:____________________________
  Tertiary:_____________________________
- ***We will expect full payment of your co-pay at the time of visit, as well as deductible responsibility***
- After your insurance has paid your claim or denied it, we will expect full payment on the balance of your account

Patient Signature:______________________________ Date:________________

Landers Physical Therapy
Covington
405 South Tyler Street
Covington, LA 70433
Phone: (985) 809-9088
Fax: (985) 809-9270

Landers Physical Therapy
Mandeville
4020 Lonesome Road
Mandeville, LA 70448
Phone: (985) 626-9591
Fax: (985) 626-9592

www.landerspt.com

Personal Representative Designation Form

You may wish to appoint a personal representative to act on your behalf as described below. In regard to this matter, the privacy of your health care information is important to us. In the spaces below, provide the requested information about yourself (the patient) and the person you are designating to act as a personal representative concerning your health care information. Once you return this completed, signed, and dated form to us, we can verify your request, adjust our records accordingly, and speak to your personal representative.

Note that, subject to the disclaimers in the following paragraph, this form can be used to document the following types of personal representative activities on behalf of the patient:

- ☑ Make appointments for health care services;
- ☑ Have discussions with health care providers about routine tests and treatments (that do not require informed consent);
- ☑ Access to medical information, as necessary, to have discussions with health care providers about routine tests and treatments.

REQUIRED INFORMATION:

Patient's Name:	Patient's Date of Birth:
Patient's Address:	Patient's Phone:
Name of Patient's Personal Representative:	Personal Representative Phone:
Personal Representative Address:	Personal Representative Fax:
Any limitations on issues your personal representative may discuss? Yes _____ No _____ If yes, please specify:	Personal Representative Fax:
Expiration date for this designation (unless/until you specify in writing the expiration, this form will remain in effect until the patient no longer receives services at Landers PT).	

REQUIRED SIGNATURE:

Patient Signature: ______________________________ Date: ________________

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME (Last, First, Middle)			DOB
ADDRESS		SSN	
CITY	STATE	ZIP	PHONE

PROVIDER AUTHORIZED TO RELEASE THE PHI:	SEND COPIES OF MY RECORD TO MY NEW PROVIDER:
	NAME Landers Physical Therapy
	ADDRESS 405 S Tyler Street
	CITY Covington STATE LA ZIP 70433
	EMAIL/FAX: 985-809-9270

This authorization will expire on the following date or event. If date or event is not indicated, authorization will expire 12 months from date signed.

PHI AND DATES OF PHI AUTHORIZED FOR USE OR DISCLOSURE

Description	Start Date	End Date
❑ Abstract of the record		
❑ Progress Notes		
❑ Laboratory Tests		
❑ X-Ray Tests / Reports		
❑ History and Physical Examination		
❑ Discharge Summary		
❑ Consultation Reports		
❑ Itemized Billing Statement		
❑ Other:		

The following information will be released when included in the above information unless you indicate otherwise:

[ ] AIDS or HIV test results
[ ] Alcohol, drug or substance abuse treatment
[ ] Psychiatric or mental care / treatment
[ ] Other (specify):

I UNDERSTAND THAT:

1. I MAY REFUSE TO SIGN THIS AUTHORIZATION AND IT IS STRICTLY VOLUNTARY.
2. MY TREATMENT, PAYMENT, ENROLLMENT OR ELIGIBILITY FOR BENEFITS MAY NOT BE CONDITIONED ON SIGNING THIS AUTHORIZATION.
3. I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN WRITING TO THE PROVIDER AUTHORIZED TO RELEASE THE PROTECTED HEALTH INFORMATION, BUT IF I DO, IT WILL NOT HAVE ANY AFFECT ON ANY ACTIONS TAKEN PRIOR TO RECEIVING THE REVOCATION.
4. IF THE REQUESTER OR RECEIVER IS NOT A HEALTH PLAN OR HEALTH CARE PROVIDER, THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS AND MAY BE REDISCLOSED.
5. I HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM AFTER I SIGN IT.

Signature of Patient:	Date:
Signature of Patient's Representative (if necessary):	Date:
Personal Representative's Relationship to Patient:	

CONSENT FOR PHYSICAL THERAPY TREATMENT

I hereby consent to evaluation and/or treatment of my condition by a licensed physical therapist employed by Landers Physical Therapy, LLC. I understand the physical therapist will fully explain to me the evaluation and course of treatment and the nature and purposes of procedures. I understand the physical therapist will inform me of the expected benefits and possible complications or discomfort, which may result from skilled physical therapy care. In addition, the physical therapist will explain to me the risks of receiving no treatment.

I understand there is no guarantee the proposed course of treatment will improve my condition; and that it is possible, although unlikely, that the course of treatment may cause additional pain, discomfort or aggravate my condition. I understand I will be given the opportunity to ask questions and the physical therapist will provide answers to the best of their ability.

I agree to cooperate and participate in all physical therapy procedures to the best of my ability and desire, to comply with the plan of care as it is established by the therapist. I further agree to remit payment(s) per my contract with my insurance carrier or other arrangements and upon receipt of an invoice for services rendered. I agree to pay the co-pays and deductibles at the time of visit.

I understand I also have the right to decline any recommended treatment. If, at any time, I am unsatisfied with Landers Physical Therapy LLC and its staff, I am encouraged to voice my concerns.

I confirm that I have read and fully understand this consent form.

Signature ______________________________ Date ________________

Please Print Name ______________________________

CONSENT FOR PHYSICAL THERAPY TREATMENT FOR MINOR CHILD

I hereby give my consent as parent/legal guardian for the minor child listed below to receive the same skilled physical therapy services as outlined above.

Child's Name ______________________________ Birthdate ________________

I also understand the same "no-guarantee", "cooperation and participation", "financial responsibility" and "declination of treatment" clauses, as listed above, apply for physical therapy treatment of the minor child.

I confirm that I have read and fully understand this consent form for treatment of a minor child.

Signature ______________________________ Date ________________

Please Print Name ______________________________

NOTICE OF PRIVACY PRACTICES
EFFECTIVE January 1, 2019

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your medical record
- Correct your medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at ________.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you
We can use your health information and share it with other professionals who are treating you.

Run our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services
We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

ACKNOWLEDGMENT: RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of Landers PT Notice of Privacy Practices effective January 1, 2019.

Name (please print): ______________________________
Signature: ______________________________
Date: ______________________________

I am a parent or legal guardian of ____________________ (patient name). I have received a copy of Landers PT Notice of Privacy Practices effective January 1, 2019.

Name (please print): ______________________________
Relationship to Patient: ☐ Parent ☐ Legal Guardian
Signature: ______________________________
Date: ______________________________

If the individual or parent/legal guardian did not sign above, staff must document when and how the Notice was given to the individual, why the acknowledgment could not be obtained, and the efforts that were made to obtain it.

Notice of Privacy Practices effective January 1, 2019 given to individual on ________ (date)

☐ In Person ☐ Mailing ☐ Email ☐ Other ____________________

Reason individual or parent/legal guardian did not sign this form:

☐ Did not want to
☐ Did not respond after more than one attempt
☐ Other ______________________________

The following good faith efforts were made to obtain the individual or parent/legal guardian's signature. Please document with dates, times, individuals spoken to, and outcome, as applicable, the efforts that were made to obtain the signature. More than one attempt must be made.

☐ In person conversation ______________________________
☐ Telephone contact ______________________________
☐ Mailing ______________________________
☐ Email ______________________________
☐ Other ______________________________

Staff Name (please print): ______________________________ Title: ____________
Signature: ______________________________ Date: ____________

Patient Rights

I. Patients have the right to be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care needs.

II. Patients have the right to be free from chemical, physical, and psychological abuse or neglect.

III. Patients have the right to refuse or withdraw consent for treatment or give conditional consent.

IV. Patients have the right to have medical and financial records kept in confidence and the release of such records shall be by written consent of the patient or the patient's representative except as otherwise required or permitted by law.

V. Patients have the right to be informed of the following:

a. Proposed procedures and the risks involved.
b. Policy on advance directives.
c. Costs of services prior to obtaining services or prior to a change in rates, chargers, or services.
d. Notice of third party coverage, including Medicare and Louisiana Health Care Cost Containment System coverage.
e. The patient grievance process.

____

Patient Name

____

Signature

____

Date

SUPPLEMENTAL

INFORMED CONSENT

Physical Therapy Treatment in the Era of COVID-19

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus", at any time or in any place. We have always followed recommended universal personal protection and disinfection protocols to limit transmission of all diseases in our office and continue to do so.

Despite our careful attention to disinfection and use of personal barriers, there is still a chance that you could be exposed to an illness in our office, just as you might be at your gym, grocery store, or restaurant. "Social Distancing" nationwide has reduced the transmission of the Coronavirus. Although we have taken measures to provide social distancing in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing between the patient, Physical Therapists, Physical Therapy Assistants, physical therapy staff and sometimes other patients at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?

(circle one)

Yes **No**

____

Patient Name

________________________ ______________

Parent/Guardian Name (if applicable) Relation

________________________ ______________

Patient/Parent/Guardian Signature Date

Supplemental Health Questionnaire

If you have been exposed to a communicable disease, you may spread the disease to the Physical Therapist, Physical Therapy Assistant, physical therapy staff, or other patients/parents in the practices. We will be asking the following questions to reduce the chances of transmission:

Patient Information

Name:______________________________

Phone:______________________________

Date of Birth:__________________________

Health Questionnaire

Do you, your child, others accompanying you to today's appointment or anyone you have recently been in contact with or have any of the following symptoms?

Fever (defined as above 99.6 degrees)? **Yes** **no**

Cough? **Yes** **no**

Shortness of breath and/or trouble breathing? **Yes** **no**

Persistent pain, pressure, or tightness in the chest? **Yes** **no**

Have you, your child, others accompanying you to today's appointment or anyone you have recently been in contact with tested positive or been diagnosed as having COVID-19 or any other communicable disease? **Yes** **no**

___ I understand that if the answer to any of these questions is yes, I may be asked to reschedule today's Physical Therapy appointment to a later date.