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

Designated Individuals Authorization Form

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____
Patient Name

_____
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:		
MEDSOUTH RECORD MANAGEMENT, LLC ON BEHALF OF LOUISIANA HEART MEDICAL GROUP ALL LOCATIONS	NAME		
	ADDRESS		
	CITY	STATE	ZIP
	EMAIL/FAX:		

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.
6. **PURPOSE: TRANSFER OF CARE TO A DIFFERENT PROVIDER OR FOR PERSONAL USE - DUE TO THE CLOSURE OF LOUISIANA HEART MEDICAL GROUP, I AM REQUESTING MY RECORDS BE RELEASED.**

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

$25 fee must accompany your request, checks should be made out to and this form should be returned to:

MedSouth Record Management, LLC
P. O. Box 1630
Mandeville, LA 70460
FAX: 985-951-7101 or Email: lhmg@medsouthrecord.com

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Notice of Patient Information Practices

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

Landers Physical Therapy Services, LLC Legal Duty

Landers Physical Therapy Services, LLC is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

Uses and Disclosures of Health Information

Landers Physical Therapy Services, LLC uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Landers Physical Therapy Services, LLC may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Landers Physical Therapy Services, LLC may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Landers Physical Therapy Services, LLC's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Landers Physical Therapy Services, LLC may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

Patient's Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Landers Physical Therapy Services, LLC will consider all such requests on a case basis, but the practice is not legally required to accept them.

Concerns and Complaints

If you are concerned that Landers Physical Therapy Services, LLC may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Landers Physical Therapy Services, LLC's health information practices or if you have a complaint, please contact the following person:

Tera Landers
Telephone: (985) 809-9088

Admission Agreement

_____ (init) Acceptance of Services

I, the undersigned, understand that by signing this agreement I voluntarily authorize provision of products and services to me by Landers Physical Therapy Services, LLC. I have received written and/or oral information about my prescribed therapy and I understand the risk involved. I also understand that these products and services are prescribed by my physician and that it is necessary that I remain in the care of my physician throughout the course of my therapy.

I have read the information about my Rights/Responsibilities and Advanced Directives and have had the Patient's Right/Responsibilities explained to me.

_____ (init) Agreement to Pay

I understand that by signing this agreement I accept full responsibility for payment of charges incurred by me for services received. I understand that Landers Physical Therapy Services, LLC will attempt to the best of its ability to obtain reimbursement for said services from my insurance carrier directly, as stated in the paragraph below, but that I will be liable for all deductibles, co-payments, and services not covered by my insurance policy unless such liability is expressly waived by state or federal law. I agree to pay reasonable attorneys' fees and costs of collection of any past due patient balances if this account is referred to an attorney or agency for collection.

_____ (init) Cancellation Policy

I understand that if I am not able to make an appointment I will give Landers Physical Therapy Services, LLC at least 24 hours notice before the appointment. If I fail to do so I understand that I will be held responsible for a 25.00 charge.

_____ (init) Authorization to Release Medical Information

I hereby authorize Landers Physical Therapy Services, LLC and/or its Billing Agent, any licensing organizations and other home care providers to review and obtain copies of my medical record, and insurance information, as they relate to my therapy, reimbursement for charges, care coordination, quality improvement, accreditation and/or licensing reviews. I also hereby authorize Landers Physical Therapy Services, LLC and/or its Billing Agent to furnish to my insurance carriers and other home care providers, any medical history, proof of services rendered or treatment needed. I understand that these authorizations take effect immediately and that a multi-part copy or photocopy is as valid as the original.

_____ (init) Assignment of Benefits Authorization

I request that payment of authorized benefits be made on my behalf to Landers Physical Therapy Services; LLC for any services furnished me by Landers Physical Therapy Services, LLC or services arranged by Landers Physical Therapy Services, LLC. I authorize any holder of medical information about me to release to Landers Physical Therapy Services, LLC and its agents any information needed to determine these 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 other approved claim forms or electronically submitted claims, my signature authorizes the release of information to the insurer or agency shown.

I authorize the release of all records required in applying for payment under Title XVIII of the Social Security Act and certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

_____ (init) Patient Information Acknowledgement Form

I have read and fully understand Landers Physical Therapy Services, LLC's Notice of Information Practices and Admission Agreement. I understand that Landers Physical Therapy Services, LLC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Landers Physical Therapy Services, LLC will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge to the use and disclosure of my personal health information for purposes as noted in Landers Physical Therapy Services, LLC's Notice of Information Practices and Admission Agreement.

_____
Patient Name

_____
Signature

_____
Date

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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