

☐ LEWES
644-2530
644-2556 Fax

☐ REHOBOTH
227-2008
227-8098 Fax

☐ MILFORD
424-1810
424-3092 Fax

☐ SMYRNA
659-0173
659-0424 Fax

☐ LONG NECK
947-4460
947-4461 Fax

☐ GEORGETOWN
854-9600
854-6511 Fax

Welcome to Southern Delaware Physical Therapy

We are glad that you are here and will do everything we can to help you. We are staffed with qualified personnel to design and direct you in your rehabilitation program so that you can return to your optimal level of function as soon as possible.

The Initial Evaluation will take approximately one hour

Please bring: prescription for physical therapy from your physician
Insurance information
Loose, comfortable clothing
Insurance referral form (if necessary)
Applicable splints or braces that you may be wearing

Follow-up appointments will be approximately one hour long. Please schedule your appointments at the front desk following your initial evaluation. Your frequency of visits may later be modified depending on the physician, the therapist, the insurance parameters, and the progress made with therapy.

Please call and cancel your appointment if for any reason you are not able to come. Failure to do so could result in a charge for the missed visit.

Children accompanying parents to therapy must remain in the waiting room and must have adult supervision. This will help insure the safety of the children.

Billing questions should be directed to our billing department at (302) 227-5550. We submit claims on a bi/weekly basis and a client statement will automatically be generated when the insurance carrier has processed the claim. The client is responsible for any balance not paid by his/her primary and/or secondary insurance company.

Please do not hesitate to ask us any questions! If at any time a procedure or an exercise causes you increased pain or discomfort, let us know! We will do our best to help you improve as much as possible.

Please keep this page for your information!

Patient Information

Last Name _____ First _____ MI _____ Date _____

Home Address (no PO Box's) _____ Home Phone _____

City, State, Zip _____ Work Phone _____

E-Mail _____ Cell Phone _____

May we contact you via e-mail with: Info Related to Your Care Updates Hours/Services

SDPT News/Events Please check all that apply.

Mailing Address if different than above: _____

Birth Date _____ Age _____ Sex M F Marital Status: S M D W

Employer _____ Attorney _____ Phone _____

Emergency contact _____ Phone _____

Spouse Information

Last Name _____ First _____ MI _____

Employer _____ Home Phone _____

Birth Date _____ Work Phone _____

If Patient is a Minor Please Complete:

Parent/Guardian's Name _____

Address (if different than above) _____

Home Phone _____

Place of Employment _____ Work Phone _____

Consent Form

Authorization to Pay Insurance Benefits:

I hereby authorize payment directly for all benefits payable to me under the terms of my insurance policy with respect to service provided for myself or my dependents.

I understand that I am financially responsible for any balance of charges not covered by my insurance including deductibles and/or co-payments and any collection agency fees if necessary.

Consent for Treatment:

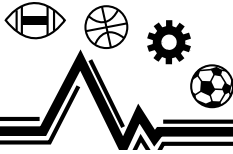
I give my consent to Southern Delaware Physical Therapy, its staff and related associates to provide outpatient physical therapy services considered necessary and proper for my diagnosis. I accept that treatment does not guarantee improvement and may, at times, exacerbate symptoms.

Authorization to Release Medical Information:

I authorize Southern Delaware Physical Therapy to release any medical information necessary to process this claim and/or coordinate my care.

Signature _____ **Date** _____

My signature indicates consent and agreement to all of the above. Signature needs to be of parent or guardian if patient is under 18 years of age.



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Notice of Privacy Practices

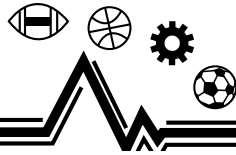
In accordance with HIPAA privacy regulations, we are notifying you as to how medical/protected health information about you may be used and disclosed. Under the law, we are required to maintain the privacy of this information, but may need to share protected health information (PHI) with others in order to process your claim or for health care operations, which may include but are not limited to:

1. Receive payment
2. Verify insurance
3. Conduct quality assessment
4. Care coordination/management
5. Manage our business
6. Assist other covered entities with their health or business operations
7. Accreditation, certification, licensing, or credentialing
8. Disclosure to the secretary of the US Department of Health and Social Services
9. Health Oversight Agencies
10. To prevent a serious threat to health or safety
11. Research
12. Workman's compensation
13. Public health and safety
14. Legal, national security or law enforcement
15. Personal physician, team physician, athletic director, or coach
16. To you or your designee upon your written request, or
17. Other uses and disclosures of PHI only after your written authorization.

ALL EVALUATION AND PROGRESS NOTES, AS WELL AS SIGNIFICANT changes in medical conditions will be reported via fax, phone, and/or mail to your referring physician, and possibly primary care physician. All insurances will be verified, with pertinent PHI being released to the insurance company(s) necessary to process claims. All patients will be asked to sign in at the front desk upon arrival. Part of treatment is performed in an open environment. Some claims are billed electronically. If you wish not to sign in on the sheet, not to have claims sent electronically, or not to be in an open area for treatment, please notify the receptionist immediately and we will attempt to make alterations to fit your needs. If you have any questions, please ask to speak to the Clinical Director. Thank you.

Patient Signature

Date



STATEMENT OF INSURANCE BENEFITS

We have verified your benefits with your health insurance company _____. According to this information, your Insurance ESTIMATES that it will pay _____. Co-insurance will be billed to the patient upon receipt of insurance payment/explanation of benefits. **Co-pays are due at the time of your visit. Your co-pay is _____.** Additional comments: _____

Southern Delaware Physical Therapy advises that you also verify your insurance benefits. The benefits stated are not a guarantee of payment; final determination is made at the time that the claims are received by the insurance company.

The following is a summary of our billing procedures at Southern Delaware Physical Therapy, Inc. As the client, it is ultimately your responsibility for paying your medical costs. As a courtesy to you, we are available to help with any questions you may have. All clients are responsible for securing and maintaining an updated prescription from the physician.

If you are a Medicare patient, your prescription is good for thirty (30) days from the date on the prescription regardless of how long the doctor has prescribed treatment. If therapy is still needed at the end of 30 days, you will need to get an updated prescription from the physician, or Medicare will not cover the costs. Medicare will not cover the costs for therapy where progress has plateaued or the client has reached functional levels. We will help monitor your progress to avoid a Medicare denial.

If any insurance payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to Southern Delaware Physical Therapy. We do not bill your third insurance. Statements are available for patient submission upon request.

If you have a Workman's Comp claim or a Motor Vehicle Accident claim, you are responsible for filing a claim with the employer or automobile insurance company prior to starting physical therapy. You need to provide our office with the following information:

1. Name, address and phone number of the carrier to be billed.
2. Claim number.
3. Date of injury/accident.
4. Name and phone number of the adjuster/contact person.

Be advised if you claim Worker's Compensation/MVA benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you. Please present any medical insurance at your first visit. Denied WC/MVA claims will be billed to medical insurance providers with whom we participate.

We submit claims on a biweekly basis and a client statement will automatically be generated when the insurance carrier has processed the claim. You are responsible for any balance due. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees. You may contact our billing office at (302) 644-8492 with any questions.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient/Guardian/Responsible Party

Date

SDPT Representative/Witness

Date

Patient Medical History Form

Name _____

Age _____

Occupation _____

Type of Work Involved _____

Do you have a history of the following:

High Blood Pressure	Yes	No	HIV/AIDS	Yes	No
Heart Condition	Yes	No	Cancer	Yes	No
Stroke	Yes	No	Seizures	Yes	No
Diabetes	Yes	No	Back/Neck Injury	Yes	No
Pacemaker	Yes	No	Other Joint Injury	_____	
Communicable Diseases	Yes	No	Other	_____	

Have you had Home Health Care for this injury/illness? Yes No

If yes, date of discharge from Home Health Care? _____

Is this injury/illness work-related? Yes No

What is the approximate date when this injury occurred or illness began? _____

When is your follow-up appointment with your doctor? _____

Have you had any surgeries in the past five years? Yes No

Please list _____

Have you had previous physical therapy? Yes No

For what condition _____

Are you taking any medications? Yes No

Please list _____

What types of activities would you like to return to?

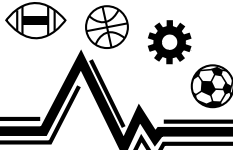
Please list _____

How did you hear about us? _____

What is the name of your referring doctor? _____

What is the name of your family/primary doctor? _____

Signature _____ Date _____



Medicare Secondary Payer Questionnaire

Medicare law requires that we determine if your medical services might be covered by another insurer. In order to assist us in the correct billing of these services, we request that you answer the following questions:

1. Are you 65 or older? Y N

2. Are you currently employed? Y N
(including self-employment and part-time) retirement date _____

If Yes, would you say the approximate number of employees your employer has is:

Less than 20 20-99 100+

3. Are you married? Y N

A. Is your spouse currently working? Y N

B. Would you say the approximate number of employees your spouse's employer has is:

Less than 20 20-99 100+

4. Are you covered through a group health plan based on your current employment or a family member's current employment? Y N

If Yes,
Name of insured: _____
Relationship to patient: _____
Name and address of employer: _____

Name and address of insurer, underwriter, third party administrator, HMO: _____

Group ID# _____ Policy ID# _____

5. Is there any other program (including government programs) which could pay for this service (e.g., Black Lung, VA)? Y N

If Yes, what program? _____

6. Screening for future fall risk.
Have you fallen in the last year? Y N

(If yes, how many times?) _____

Under what circumstances? _____

7. Is this service related to an accident or injury that occurred on the job? _____ Y _____ N

If Yes,

Date of accident or injury: _____

Name and address of employer: _____

Name and address of the worker's compensation agency
or plan: _____

File/Case# _____

8. Is this service for the treatment of an illness or accident for which another party could be held responsible? _____ Y _____ N

If Yes,

Name and address of the no-fault or liability insurer:

Policy# _____ Accident Date# _____

Type of accident: _____

Name of insured: _____

9. Are you a member of a Health Maintenance Organization (HMO)? _____ Y _____ N

If Yes, is this HMO coverage through a Group Health Plan? _____ Y _____ N

10. Have you received a kidney transplant or dialysis treatments? _____ Y _____ N

If Yes,

What was the date of the transplant? _____

What was the date maintenance dialysis began? _____

Have you received self-dialysis training? _____

11. Do you require vocational services while you are receiving physical therapy at this facility? _____ Y _____ N

12. Have you been classified as a disabled individual through Medicare or any other government agency? _____ Y _____ N

13. Do you receive government financial assistance due to an injury or illness? _____ Y _____ N

14. Were you working prior to your injury but unable to work since the injury for which you are being treated? _____ Y _____ N

Thank you very much.