CHARLESTON ORTHOPAEDICS
& SPORTS PERFORMANCE

TODAY'S DATE: _____

Patient Registration

Name: _____ Phone number: (_____) _____-_____

Address: _____

City:_____ST: _____ Zip: _____

Date of Birth: _____/_____/_____ Sex: M / F Marital Status:_____ SSN: _____

Email address: _____

Referring Physician: _____ Primary Physician: _____

Whom may we contact in case an emergency? _____Phone number: (_____) _____-_____

INJURY/ACCIDENT INFORMATION

Date of Onset of Injury/Problem: _____ Date of Surgery: _____

Have you had any previous physical therapy services this year? Y / N Dates: _____

Employment Related: Y / N _____ Initials Accident Related: Y / N

PATIENT EMPLOYMENT/STUDENT INFORMATION

Employer: _____ Occupation: _____

Student: Y / N School: _____

INSURANCE INFORMATION - please present insurance card

Employer of Insured: _____ Date of Birth:_____

Primary Insurance: _____ Insured Name: _____

Group #: _____ ID#: _____ Relationship to Patient:_____

Secondary Insurance: _____ Insured Name: _____

Group #: _____ ID#: _____ Relationship to Patient: _____

WORKER'S COMPENSATION INFORMATION

Worker's Compensation Company (If applicable): _____

Supervisor/Case Worker: _____ Telephone: _____

Case Number: _____ Claim Number:_____

PLEASE READ AND SIGN

I authorize Charleston Orthopaedics & Sports Performance to release to my insurance company any information necessary to file claims for service rendered. I also authorize payment of medical benefits to Charleston Orthopaedics & Sports Performance. I further understand that I remain responsible to Charleston Orthopaedics & Sports Performance for any and all charges not paid by my insurance company.

_____ _____

Patient / Guardian Signature (if the patient is a minor {under 18 yrs of age} guardian must sign) Date

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TODAY'S DATE: _____

Patient Medical History

Your medical history is very important information for us to ensure your safety during your rehabilitation process. Please be as complete as possible with your answers, and feel free to discuss your history with your therapists.

Do you have a history of the following? YES/NO

Diabetes Y / N
Heart Disease Y / N
Cardiac Pacemaker Cancer Y / N
Stroke Y / N
High Blood Pressure Y / N
Gastrointestinal problems Y / N
Lung Disease Y / N

Please list any significant surgeries you have had in the past five years:

_____ Year _____
_____ Year _____
_____ Year _____
_____ Year _____

Current Medications:

_____
_____
_____
_____

What diagnostic test(s) have been performed for your current condition and where were they done?

X-ray _____
MRI _____
CT _____
EMG/NCV _____
Blood work _____
Other: _____

Have you received physical or hand therapy for your current condition? Y / N

If Yes, When and where, and how long? _____

Have you experienced any of the following :

Persistent pain at night Y / N
Fever or night sweats Y / N
Are you pregnant Y / N
Loss of appetite Y / N
Shortness of breath Y / N
Dizziness Y / N
Frequent nausea or vomiting Y / N
Recent unexplained weight loss Y / N
Frequent or severe abdominal pain Y / N
Unusual menstrual irregularities Y / N
Frequent heartburn or indigestion Y / N

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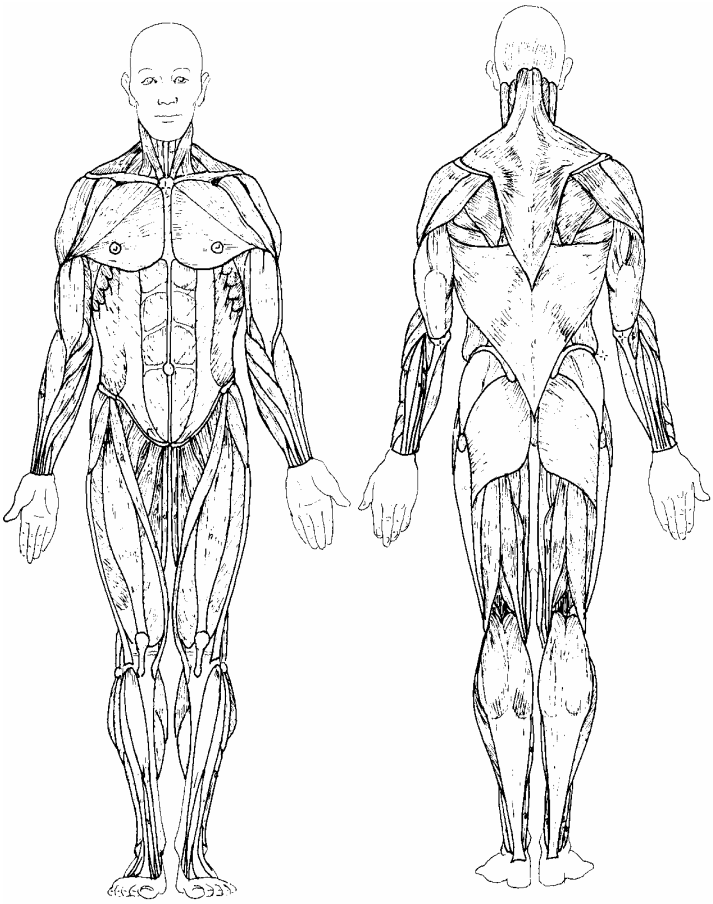
Patient Medical History (con't.)

Please circle the area(s) that is painful.



Other medical history :

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Patient Billing Information

Charleston Orthopaedics & Sports Performance (COSP) would like to welcome you to our clinic. The following information should be helpful in answering some common questions regarding our billing procedures and insurance filing.

*** Please be aware that COSP is a separate company from your referring physician. Therefore any payments made at your physician's office will not be applied to your COSP account.***

As a courtesy, a billing representative will call your insurance company to inquire about your benefits for outpatient physical or occupational therapy. This is not a guarantee of payment. Non-payment of premiums and other contractual limitations may result in denial of benefits or refunds. _____ Initials

***** COSP is out of network for any insurance company that is not listed below ******

Even if your insurance company is listed below, it is necessary to refer to your individual policy or contact your insurance company so that the highest benefit structure will be provided for you.

We are preferred providers and accept assignment for the following insurance companies:

Aetna

Medicare

Blue Cross Blue Shield

United Healthcare

*** Patients involved in auto accidents will be responsible for the balance of their account. Upon written request from the auto insurance, we will supply any needed information, however, the patient is responsible for filing these claims. _____ Initials

*** If your insurance company states that you are responsible for a co-payment per visit, that co-payment will be collected at the time of service. _____ Initials

*** Once your insurance company has sent the first payment, you will begin to receive a monthly statement from our billing department as well as an explanation of benefits from your insurance company. Please be aware that if you have been treated for more than one visit, your statement will include both paid and unpaid services. _____ Initials

*** If you have any questions regarding your account, please contact our billing department at (843) 284-8603.

I authorize Charleston Orthopaedics & Sports Performance to release to my insurance company any information necessary to file claims for services rendered. I also authorize payment of medical benefits to Charleston Orthopaedics & Sports Performance. I further understand that I remain responsible to Charleston Orthopaedics & Sports Performance for any and all charges not paid by my insurance company.

_____ _____

Patient / Guardian Signature (if the patient is a minor {under 18 yrs of age} guardian must sign) Date

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& SPORTS PERFORMANCE

TODAY'S DATE _____

Consent Forms

General Consents

1. I understand that COSP works with accredited academic institutions, through clinical affiliations, to provide healthcare professionals in training with hands-on patient care experiences and opportunities to apply learned skills to actual patient care. I further understand that such healthcare professionals in training may be involved in my care.

2. I understand that COSP will not be responsible for the loss, destruction or theft of any of my personal property. I take full responsibility for, and release COSP from, any and all responsibility and/or liability for the loss, destruction or theft of my personal property at, or in the vicinity of the COSP clinic.

3. I understand and acknowledge that COSP may lease or license real estate, equipment, or other personal property (collectively "Leased Property") from third parties to perform the evaluation and treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition. In consideration of being permitted to make use of and/or have access to the Leased Property, I do hereby, on behalf of myself, on behalf of any minor or other person for whom I have requested such evaluation and treatment procedures ("Minor"), on behalf of my heirs, successors and assigns, and on behalf of such Minor's heirs, successors and assigns release and forever discharge any and all direct or beneficial owners of the Leased Property and their respective successors, related entities, directors, officers, employees, and agents (collectively, "Releasees") from, and hereby waive and release, any and all claims, demands, actions, and causes of action whatsoever arising out of or in any way related to any loss, damage, or injury, including death, that may be sustained by me and/or such Minor in, on, upon, in connection with or while making use of the Leased Property, regardless of whether any such loss, damage, or injury is caused by the active or passive negligence of the Releasees or otherwise and regardless of whether any such liability arises in tort, contract, strict liability or otherwise, to the fullest extent allowed by law. This paragraph does not release any claims, demands, actions, and/or causes of action against COSP.

4. I understand that I am not permitted to take pictures or make video or audio recordings at the COSP clinic or of my care, other patients or COSP personnel.

5. I understand that to ensure that patient inquiries are handled promptly, courteously, and accurately, some of the phone calls between COSP (or any of its affiliates, agents, assigns and service providers) and me (or anyone I have authorized to speak with COSP) may be monitored and/or recorded.

6. I understand and consent that COSP may from time to time make calls and/or send text messages to any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me and/or the account holder. I understand and consent that the manner in which these calls or text messages are made may include, but is not limited to, the use of prerecorded/artificial voice messages and/or automatic telephone dialing systems. I understand that I am not required to agree to this provision as a condition of receiving services and that my consent may be revoked at any time.

7. I understand and consent that COSP may send emails to me at any email address provided to COSP and/or use other electronic means of communication to the extent permitted by law. I understand that I am not required to agree to this provision as a condition of receiving services and that my consent may be revoked at any time.

8. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of services and fully understand that I am financially responsible for any services not covered by this authorization.

9. I have presented myself to this facility for physical therapy treatments and consent to diagnostic procedures and care provided by my attending physical therapist.

10. I realize I have the right to refuse any drugs, treatments, and procedures to the extent permitted by law. I acknowledge that medicine is not an exact science, no guarantees or warranties can be made to me regarding the results of any treatments at this facility. I understand that information from any medical record(s) kept by this facility may be used for educational administrative, and/or facility approved purposes when my personal identity will not be revealed.

11. **NOTE TO WORKERS COMP** I hereby authorize my rehab consultant to receive my records related to my work injury. This information may be faxed or mailed.

12. I understand if I do not attend physical therapy for two weeks or miss three consecutive appointments that I am subject to discharge. Once I have been discharged, I understand that I will need a new physician's order/referral for any further therapy and will be receiving a new evaluation. This is in compliance with the South Carolina State Law.

13. I understand and acknowledge that my appointment times are scheduled in accordance with availability of professional staff. I understand that my appointment may be rescheduled by COSP if I arrive more than **15 minutes late**. I also acknowledge that COSP requires 24 hours' advance notice of cancellation and that COSP reserves the right to charge a $40.00 cancellation fee if I fail to cancel an appointment at least 24 hours in advance.

14. I understand that I may receive a bill for services and are responsible for any balance not covered by my insurance plan.

I have read and fully understand the above general consents and any questions I may have had, have been answered to my satisfaction.

_____ _____

Patient / Guardian Signature Date

(if the patient is a minor {under 18 yrs of age} guardian must sign)

Consent to Communicate

I hereby authorize Charleston Orthopaedics & Sports Performance (COSP), through its appropriate personnel, to communicate with the individual listed below regarding **medical treatment, billing and payment for services rendered on my behalf, or in case of emergency**.

Contact name: _____

Relationship: _____

Contact's phone number: _____

OR

I wish to **decline** authorization for others to communicate with COSP on my behalf. Initials _____

Notice of Privacy Practices

By signing this notice, you acknowledge that you have been offered a copy for review of COSP's Notice of Privacy Practices in which copies are available in the clinic and available on our website. This Notice of Privacy Practices provides information about how we may use and disclose your protected health information. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice.

_____ _____

Patient/Guardian Signature Date

(if the patient is a minor {under 18 yrs of age} guardian must sign)

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Summary Notice of HIPAA Privacy Practices

This summary notice of privacy practices serves to inform you how Charleston Orthopaedics & Sports Performance (COSP) may use and disclose your protected health information (PHI). COSP creates and maintains a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. We are required by law to protect the health information that identifies you and inform you of our legal duties and privacy practices.

Uses and Disclosures of Protected Health Information (PHI) by Patient Consent

• **Treatment**: We may use PHI to provide you with health care treatment or services. This includes but is not limited to discussions with referring physicians to plan care and treatment.
• **Payment**: We may use and disclose PHI to a third party or insurance company to obtain benefit information and prior approval for treatment or to justify medical care.
• **Health Care Operations**: We may use and disclose PHI to ensure that you are receiving the highest quality of care.

Uses and Disclosures of Protected Health Information (PHI) as Required by Law

We will disclose PHI about you when required to do so by federal, state or local law. Such examples are:

- To avert a serious threat to health or safety
- For military personnel or veterans, supply PHI to military command authorities or Dept of Veterans Affairs
- Supply information regarding Workers' Compensation claims to insurance companies, case managers or employers
- Public health risks
- In response to a subpoena, court order or other lawful request
- Supply information to a Health Oversight Agencies for activities authorized by law (audits, investigations, inspections, licenses)
- Law Enforcement requests
- Coroners, Health Examiners and Funeral Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- Inmates

Your Rights as a Patient to your Protected Health Information (PHI)

- You have the right to inspect and copy your medical records.
- You have the right to request an amendment to your medical records. COSP however, is not required by law to change your records.
- You have the right to request an accounting of the disclosures COSP has made.
- You have the right to request restrictions or limitations on your PHI.
- You have the right to request confidential communications.
- You have the right to obtain a copy of this notice at any time. ** For all requests, please note that COSP has 30 days to respond to your request and has the right to charge you copying fees.

Complaints −If you believe that your privacy rights have been violated, you may file a complaint with us or with the Secretary or the Department of Health and Human Services. To file a complaint with us, please contact the Privacy Officer at 843-284-8603. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Changes to this Notice − COSP reserves the right to change this notice at any time. We reserve the right to make the revised notice effective for health information we already have about you as well as information we receive in the future.

Consent to Use and Disclose Protected Health Information (PHI) - By signing this document, I agree to truthfully, completely and correctly provide all requested information to COSP. Additionally, I am giving consent to COSP to use and disclose my protected health information for treatment, payment and health care operations.

Patient Name_____ Patient / Guardian Signature _____
Date_____ (if the patient is a minor {under 18 yrs of age} guardian must sign)

Witness_____ Date_____
*THIS WITNESS MAY ACCEPT CONSENT VERBALLY, BY TELEPHONE, OR ELECTRONIC MEANS