

# Whitefish Physical, Occupational and Speech Therapy Patient Intake Form

Patient Information					
Patient Name	Birth Date	Social Security #		Marital Status	Gender
				S M W D	M F
Mailing Address	City	State	Zip	Home Phone #	
Physical Address	City	State	Zip	Cell Phone #	
Occupation	Employer & Work Address			Phone #	
Primary Care Physician	Emergency Contact Name		Contact Phone #	Contact Relationship	
Who can we thank for referring you to our clinic or how did you find us (Phone Book, Web Site, Newspaper, etc.)?					
Would you like to help us to be environmentally friendly and receive our newsletter via e-mail?    YES    NO					
E-mail address:					

Injury Information			
Date of injury	Date of Surgery	Type of Surgery	Referring Physician
Was Injury Work Related	Employer Name and Address At Time of Injury		
If Work Related – Claim #, Case Manager/Claim Adjustor Name and Phone #			

Other Important Information
Have you had any Physical, Occupational or Speech Therapy this year?    YES    NO    If yes, how many visits?    PT_____    OT_____    ST_____
Are you receiving Home Health Services of any kind at this time?    YES    NO <b>If Yes, please inform receptionist at this time.</b>
Have you received Home Health Service of any kind in the past?    YES    NO    If Yes, what was your date of discharge (your final visit)? _____

Regarding Privacy
Please initial the following that are acceptable to you;
WPOST/VPS staff may leave messages with someone at my home _____
WPOST/VPS staff may leave a message on my voicemail/answering machine at home _____, work _____, or cell phone _____
WPOST/VPS staff can discuss my account with the following individual _____.
I give my consent for treatment; authorize the release of necessary information to insurance carriers and appropriate personnel and request that my insurance carriers pay WPOST directly. If direct payment is not permitted, I request that payment be issued jointly to WPOST and myself and mailed directly to WPOST. I will endorse checks so that WPOST may cash and apply monies to my account accordingly. I understand that I am financially responsible for any and all charges incurred and that I will be charged interest in the amount of 10% APR for balances 90 days or more past due. In the event my account is referred to a debt collector, I understand I will be responsible for all costs incurred to collect the debt in addition to my account balance.
Patient/Guardian Signature
Date

## **IMPORTANT BILLING INFORMATION**

- **Venture Practice Services, Ltd.** will be billing your insurance carrier for all services performed by Whitefish Therapy.
- You will be receiving periodic statements from Venture Practice Services.
- The billing system is designed to bill the patient every 28 days for balances due after the insurance payment is received or denied.
- Charges and payments are itemized on your statement only once, so please keep them for your records. If the current balance is not paid within 28 days, it will appear as a balance forward on your account the following month.
- Delinquent accounts are those with balances that remain unpaid after two statements. A final letter is sent with the third statement.
- If you are an injured worker and your claim is allowed, we will submit your charges to the appropriate workers' compensation carrier. If for any reason WC disallows your claim, you will be billed for the balance due.
- *If you have a legal case or auto accident pending, you will need to make prior arrangements for payment with our office and complete a **Personal Injury Information** form.*
- Signing a waiver indicates that you are aware that you are responsible for anything your insurance does not cover.
- Please notify us immediately of all changes or updates regarding your insurance & address.
- If you have any questions or concerns regarding your statement, please contact one of our patient account representatives who will be happy to assist you.
- Venture Practice Services may be reached at (330) 865-1600 or 800-680-6873.
- Payments may be directed to:

Whitefish Therapy  
PO BOX 4357  
Whitefish, MT 59937-4357

I have read and received a copy of the Important Billing Information listed above.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# SPORTCENTER

SPEECH • PHYSICAL • OCCUPATIONAL • REHABILITATION • TRAINING

**2006 Hospital Way  
Whitefish, MT 59937  
(406)862-9372**

## **HIPPA NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. 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 healthcare 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 physician, our office staff and others outside of our office that you are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the clinicians practice, and any other use required by law.

### **Treatment**

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any 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/healthcare professional to which you have been referred to ensure that the physician/healthcare professional has the necessary information to diagnose or treat you.

### **Payment**

Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, your health information may be provided to an attorney or law firm that is representing you on a claim.

### **Healthcare Operations**

We may use or disclose, as needed, your protected health information in order to support the business activities of your clinicians practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of physical therapy students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to physical therapy students that see patients at our office. In addition, we may call you by name in the waiting room when your Therapist/Athletic Trainer is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of an 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; Organ Donations; Criminal Activity; Military Activity; National Security; Worker's 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 Athletic Trainer or athletic training practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**You have the right to inspect and copy your protected health information.** This means that you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health 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 Therapist/Athletic Trainer is not required to agree to a restriction that you may request. If your Therapist/Athletic Trainer 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.

**You have the right to request to receive confidential communications from us by alternative means or at any alternative location. You have the right to obtain a paper copy of this notice from us upon request.**

**You have the right to have your Therapist/Athletic Trainer amend your protected health information.** 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.

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

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.

**Complaints**

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 of your complaint. **We will not retaliate against you for filing a complaint.**

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

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 Deborah Pacheco, our HIPPA Compliance Officer, in person or by phone at 406-862-9372.

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

**Print Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_