MEDICAL HISTORY

Patient Name: ____ DOB: ________________________

Address: ____

Phone: ____________________ Email address: ____

Primary Care Physician: __________________________________ Phone Number: ______________________

Primary Ins Name: _________________________ Secondary Ins Name: _____________________________

Preferred method of contact for upcoming appointments: ☐ text ☐ email

Have you ever, or are you presently being treated for any of the following problems?

		Yes		No			Yes		No	Do you or have you had any of the following symptoms:				
Heart Trouble					Asthma									
High Blood Pressure					Emphysema									
Diabetes					Back Injury									
Headaches					Arthritis									
Dizzy Spells					Bleeding Disorder									
Fainting					Fracture					Productive Cough		Yes		No
Epilepsy					Cancer					Coughing Blood				
Stroke					Pacemaker					Weight Loss				
Pregnancy					Implants/Metal					Appetite Loss				
Seizures					Respiratory Problems					Lethargy				
Allergies					Tuberculosis					Night Sweats				
*Specify ________________					Hepatitis A/B/C					Fever				

Date of injury: _________________ How did the injury occur? ____

____

Have you been hospitalized for the present problem? ☐ yes ☐ no If yes, dates: ___________________________
Have you undergone surgery for the problem? ☐ yes ☐ no If yes, dates: ___________________________
Have you had previous treatments for the problem? ☐ yes ☐ no If yes, specify Types/Results of treatment:

____

Are you currently receiving any other health, medical, or chiropractic services or by any other organization or individual at this time? ____

____

Last Date seen by Physician: ____________________ Next appointment with Physician: ____________________

Are you on any medications: ☐ yes ☐ no ____

Have you ever had any of the following for the present condition for which you are going to be treated?
EMG ☐ yes ☐ no CAT Scan ☐ yes ☐ no Myelogram ☐ yes ☐ no
X-Ray ☐ yes ☐ no MRI ☐ yes ☐ no

Would you be interested in purchasing/receiving an eStim unit/TENS unit? ☐ yes ☐ no

Have you ever received PT/OT/Speech Services for your present condition? ☐ yes ☐ no

If YES, where and when? ____

****Medical Disclaimer and Liability:**
During your treatment at RTBTS, you will be educated about certain medical conditions and provided with specialized treatment, including modalities. Information received should not be relied upon as an alternative to the advice of your physician. If you have specific questions/concerns, contact your physician.
By signing this form, you agree to never disregard medical advice, delay physician treatment, or discontinue medical regimes given the information provided @ RTBTS.
By signing this form, you agree that the Therapists and Assistants at RTBTS are not liable for any dangers/damages arising from or related to your treatment.

I believe the above to be true and correct to the best of my knowledge:

Patient (representative) Signature: ____ Date: __________________________________

Therapist Signature: ____ Date: __________________________________

Consent for Treatment

Notice of Privacy Practices is a complete description of the rights of the patients at “Raise The Bar Therapy Services LLC” Outpatient Clinic with respect to patients’ information and how the patient information is protected. I have been given the opportunity to review the Notice of Privacy Practices prior to signing this consent. By signing below, I am stating I have received the Notice of Privacy Practices of RTBTS, LLC.

Patient (or authorized representative): ____

Consent for Treatment: I consent to treatment/care, as determined to be necessary, by Raise The Bar Therapy Services, LLC. I am aware that the practice of therapy is not an exact science and I understand that no guarantees have been made to me about the results of treatments or procedures.

Consent for Use and Release of Information:

I give permission to RTBTS therapists and other staff members to release any information about me, my health, the health services provided to me, or payment for my health services which may be necessary.

1. In regard to Treatment Regime: To my referring physician, any physician treating me, and or other healthcare providers or facilities which need the information to continue my care.
2. In regard to Payment: To determine my insurance eligibility, and if treatment is authorized for payment by my insurance or public benefits. Information will be used to process the claim, for utilization and quality review, or for billing collection which includes but is not limited to; medical staff, outside providers, companies billing on behalf of RTBTS.
3. In regards to the daily operations of RTBTS: To operate its business more efficiently, and to improve quality and appropriateness of care.

Financial Responsibility:

I understand and agree that:

1. The actual therapy charges for professional services performed by a licensed therapist may be different from the estimates given to me.
2. An insurance company may pay the full amount of my charges, and I may be responsible for the amount not paid.
3. I am responsible for supplying accurate information and that the insurance is filed as a courtesy and if payment is denied that balance for services rendered is my responsibility.
4. I am responsible for all copays at the time of service.
5. I understand that if a check is returned from my banking institution, an additional $25.00 processing fee will be added to my account. After 3 returned checks, RTBTS will no longer accept this method of payment for services rendered.
6. I understand that if I do not show for a scheduled appointment or do not give 24-hour notice, there will be a $25.00 No Show fee added to my account. After the third no show, I will no longer be a patient of RTBTS, treatment plan will be terminated.

Consent for Treatment Continued: Medicare/Medicaid Insurance Certification, Assignment & Payment

I have been notified that Medicare will only pay for services that are deemed necessary and appropriate, under section 1862 (a/l) of the Medicare Law. I certify that the information given in applying for payment under Titles XVIII and XIX of the Social Security Act, is correct. I request that payment of authorized benefits be made to the health care provided on my behalf. I hereby authorize Raise The Bar Therapy Services, LLC to bill for directly and assign the right to all health and liability insurance benefits otherwise payable to me and authorize direct payment to the health care system provider.

Social Security Number: I have given my social security number voluntarily. RTBTS may use it for accurate identification, filing insurance claims, billing and collections, and compliance with federal and state laws.

This consent will be effective for outpatient visits for one year after the date on which it is signed, unless replaced by a new consent form. It will not expire with respect to any services or processing of claims related to admissions or visits occurring while this consent is in effect.

I understand that I may withdraw this consent in writing, and my withdrawal will not be effective for actions already taken by Raise The Bar Therapy services, LLC or in process.

Raise The Bar Therapy Services, LLC is authorized to release all records required to act on these requests. I have read and understand this form, I have received a copy and I am the patient or authorized representative to act on behalf of the patient to sign this form.

Patient Signature: ____ **Date:** _______________________

Printed Name: ____

Relationship if not patient: _________________________________

Witness: ____ **Date:** _______________________

GUARANTOR: If I sign below as a guarantor (not as the patient or spouse, or the parent of a minor child) I agree to pay all charges of RTBTS, LLC not paid, whether or not I am otherwise legally obligated to pay.

Guarantor signature: _________________________________ **Printed Name:** _____________________________

Health Insurance Benefit Information

Patient's Responsibility:

- To know your insurance policy.
  - You should be aware of your benefit coverage including:
    - covered and non-covered benefits, and
    - cost share information such as deductibles, co-insurance, and co-pays.
  - If you are not familiar with your plan coverage, we recommend you contact your carrier directly.
- Any non-covered services are your responsibility.
- To pay your co-pay at the time of service.
- To pay any deductible and co-insurance amounts not covered by your supplemental insurance.
- To review the Explanation of Benefits (EOBs) received from the insurance company and if claim was not covered, to contact the insurance company to inquire reason.

Raise the Bar Therapy Services will:

- As a courtesy, contact your insurance company to confirm:
  - Participation with your plan
  - Effective/end date, if coverage is currently active and therapies covered.
  - If there are a maximum number of visits allowed.
  - If there is a co-pay, deductible and/or co-insurance.

The insurance company may not give us the correct information so it will be up to you to confirm what they have told us is correct.

When a payment is collected at the time of check-in, it is applied to that date of service. When it is applied to your account by the billing service, it will be applied to the oldest processed claim which means they dates may not match when we provide a statement and patient payment record. It will go toward your deductible and/or out of pocket for the year paid even if it is applied to a claim from the previous year.

RTBTS has the responsibility to provide you with the best possible care. When you schedule your appointment, you are committing to remaining compliant with the Plan of Care determined by the doctor and therapist to assist in your recovery. We at RTBTS do understand that sometimes things happen, and you might not be able to attend appointments as anticipated. When this happens, please contact our office as soon as possible when cancellation or re-scheduling is required. The therapists are scheduled to be here to provide care to their patients and must be paid by RTB even if the patient a no-show.

Patients who no-show for a scheduled appointment without a 24-hour notice will incur a charge of $25. After the third (3rd) no show, you will no longer be a patient of Raise the Bar Therapy Service, treatment plan will be terminated, and the referring physician's office notified of such.

______________________________	______________________
Printed Name	Date
______________________________	______________________
Signature	Relationship to Patient

ADULT HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

I, ____ give authorization for release of my protected health information (PHI) to **Raise The Bar Therapy Services, LLC** regarding my billing, condition, treatment and prognosis to the following individual(s):

- Name ____________________________________ Relationship ____________________
- Name ____________________________________ Relationship ____________________
- Name ____________________________________ Relationship ____________________

I understand that I have the right to revoke this authorization verbally and/or in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

I understand that information used or disclosed pursuant to this authorization my be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient ____

Date ____

18676 Highway 17
Hampstead, NC 28443
Ph: 910-821-1700
Fax: 910-319-9105
jewel@rtbtherapy.com

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Printed Name of Patient: ______________________________________Date of Birth: ___________________

My Authorization to Raise the Bar Therapy Services

I authorize the following using or disclosing party:

____

(Name of Hospital or Doctor) (Phone Number)

to use or disclose the following health information:

☐ - All of my health information

☐ - My health information relating to the follow treatment or condition: ________________________________

☐ - My health information covering the period from (date) _____________ to (date) _____________________

☐ - Other: ____

The above party may disclose this health information to the following recipient:

Raise The Bar Therapy Services
18676 US Hwy 17N
Hampstead, NC 28443
Phone: (910) 821-1700
Fax: (910) 319-9105
Email: Jewel@rtbtherapy.com

The purpose of this authorization is:
☐ - At my request
☐ - Other ____

This authorization ends: (date) ____

My Authorization from Raise The Bar Therapy Services

I authorize Raise The Bar Therapy Services to provide my records to the following healthcare facility:

Name of Facility or Doctor: ____

Phone Number: _________________________________ Fax Number: __________________________

This authorization ends: (date) ____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: ____

Date: ____

<u>If the patient is a minor or unable to sign, please complete the following:</u>

☐ - Patient is a minor: _____ years of age

☐ - Patient is unable to sign because: ____
Ex: medical condition, injury

Signature of Authorized Representative: ____

Date: ____

Print Name of Authorized Representative: ____

Authority of Representative to sign on behalf of the patient:

☐ - Parent ☐ - Legal Guardian ☐ - Court Order

☐ - Other: ____

Notice of privacy practices regarding protected health information about you may be used and disclosed and how you can get access to this information.
Please review this document carefully

Raise the Bar Therapy Services, LLC (RTBTS) is required by law to maintain the privacy of your Protected Health Information (PHI) and to provide you with novice of its legal duties and privacy practices with respect to you PHI. If you have questions about any part of this notice or if you want more information about the privacy practices at RTBTS, please us at:

18676 US-17N
Hampstead, NC 28443
Effective date of this notice: _________

I. How RTBTS May use or disclose your PHI:

RTBTS collects your health information and stores in in the computer. This serves as your medical record. The medical record is the property of RTBTS but the information contained within belongs to you. RTBTS protects your PHI for the following purposes:

1. Evaluation and Treatment: RTBTS will use and disclose your PHI while providing your healthcare in coordination with the referring provider. That information us used to determine your course of treatment that is best for you. The evaluating therapist will initial assessment and then other members of your therapy team will have access to document in your record as they are following the plan of care (POC).
2. Payment: RTBTS will use and disclose your PHI to obtain or provide compensation or reimbursement for providing your health care services. RTBTS will remit a bill to your insurance provider or health plan and the information will include identifying information, diagnostic codes, planned treatment regimen, and possible supplies to be utilized. This information may be disclosed in order to assist in determining your eligibility for payment of services.
3. Regular Healthcare Operations: You PHI will be used to manage administrative aspects of your care such as to assess the quality of care and outcome measures in your case, in order to improve the provision of care.
4. Public Health: As required by law, RTBTS may disclose your PHI to public health authorities for purposes related to disease control, injury or disability, child abuse or neglect, or the reporting of domestic violence.
5. Required by Law: RTBTS may use and disclose your PHI as required by law.
6. Worker's Compensation: RTBTS may disclose your PHI as necessary to comply with Worker's Compensation Laws.
7. Law Enforcement: RTBTS may disclose your PHI to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.
8. Business Associates: RTBTS may grant access of your PHI to business associates in order to have them perform a business function, however those associates must uphold the same requirement of privacy as RTBTS.
9. Notification/Familial Communication: RTBTS may communicate and disclose PHI to your family with your consent, in regard to your location, general condition and your therapeutic needs. If you are unavailable to

agree or object, our healthcare professional will use their best judgment in communication with your family and others.

10. Research: healthcare review boards will sometimes request information for educational purposes and this will be provided after receiving approval by an Institutional Review Board.
11. Public Safety: RTBTS may disclose your PHI to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
12. Health Oversight Activities: RTBTS may disclose your PHI to health agencies during the course of audits, investigations, inspections, licensure survey and other such proceedings.
13. Judicial Proceedings: RTBTS may disclose your PHI in the course of any administrative or judicial proceedings as required by law.
14. Change of Ownership: IN the event that RTBTS is sold or merged with another organization, your PHI will become the property of the new owner.
15. Marketing/Scheduling: RTBTS may contact you regarding upcoming appointments and/or any opportunities that may be of interest to you.

II. **Raise The Bar Therapy Services May Not Use or Disclose Your Protected Health Information** except as described above, will not do so unless authorized with your written consent. If you authorize discloser for any other purpose than that which is written above, you reserve the right to revoke it in writing at any time.

III. **PHI Rights:**

1. Although you have the right to request restrictions on certain uses and disclosures of you PHI, RTBTS is not required to agree to those restrictions as governed by law.
2. You have the right to received your PHI though whatever means you deem acceptable, for example to be contacted at a certain location, but this request must be made in writing.
3. You may review and copy your PHI after submitting our request in writing to the address below through the owner of the company. If you request a copy of your PHI, RTBTS may charge you a fee for the cost of the copying, mailing, and supplies utilized.
4. You have the right to request that RTBTS amend your PHI if incorrect or incomplete, however, RTBTS is not required to change your PHI and will provide you with information about the denial and how you can appeal it.
5. You have the right to receive an account of disclosures of your PHI made by RTBTS except those which RTBTS does not have to account for as described in Section I of this Notice of Privacy Practices. (Treatment, Payment, Healthcare Operations, and Business Associates).
6. You have a right to a paper copy of this Notice of Privacy Practices.

IV. **Changes to this Notice of Privacy Practices**

RTBTS reserves the right to change this notice or add amendments at any time in the future, to make new provisions effective for all the information that it maintains including the information that was created or received prior to the date of the amendment. Until such amendments are made, RTBTS is required by law to comply with this Notice.

V. **Complaints**

Complaints about the above Privacy Practices or how RTBTS handles your PHI should be directed to the main office at 16579 Highway 17 Hampstead, NC 28443
Phone: 910-821-1700.

If you are not satisfied with the manner in which the office handles a complaint you may submit a formal complaint to: Department of Health and Human Services, Office of Human Rights Hubert H. Humphrey Building, 200 Independence Ave SW, Room 509F HHH Building Washington, DC 20201. OR you may also address your complaint to the Regional Office for Civil Rights and the list of these offices can be found online at http://www.hhs.gov/ocr/regmail.html.

18676 Highway 17
Hampstead, NC 28443
Ph: 910-821-1700

CREDIT CARD AUTHORIZATION

- **NO SHOW/LATE CANCELLATION FEES**
- **INSURANCE COPAYS & DEDUCTIBLES**
- **THERAPY FEES**

In order to provide you and other patients of Raise the Bar Therapy Services the best possible care, a minimum of 24 hours' notice is required to cancel or reschedule your appointments.

I, ____, understand the importance of notifying Raise The Bar Therapy Services **at least 24 hours** prior to my (or my child) scheduled appointment that I am not able to keep the appointment. If I am experiencing an emergency, I will provide as much notice as possible to avoid being charged the Late Cancellation fee of $25. I understand that I will be charged a No-Show fee of $25 for failing to call and failing to show for my scheduled appointment.

As per this agreement, the credit card on file will also be used for my remaining portion (co-payment, deductibles, and fees) unless I notify the administrator of a change in credit card status (i.e. cash payment).

I understand that I may revoke this agreement at any time by providing a request in writing. I am also aware that when services rendered by Raise The Bar Therapy Services have ended, this form shall be shredded once I am terminated from treatment.

I am requesting/authorizing that this card be used for payment of services (co-pay, deductibles & fees):

____ Yes ____ No

Name on card: ____

Card Number: _______________ - _______________ - _______________ - ________________

Expiration Date: __________ / ___________ Code: ___________

Street Address: ___________________________ Zip Code: __________________

Email address for receipt: ____

Patient Name (printed): ____

Patient (or Parent/Guardian)/Card Holder Signature:

____ Date: __________