

<b>PATIENT INFORMATION</b>	<b>DATE:</b>
<b>Name:</b> _____ <b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <div style="display: flex; justify-content: space-between; width: 80%; margin-left: 10px;"> <span><i>Last</i></span> <span><i>First</i></span> <span><i>M.I.</i></span> </div>	
<b>Address:</b> _____ <div style="display: flex; justify-content: space-between; width: 80%; margin-left: 10px;"> <span><i>Street</i></span> <span><i>City, State</i></span> <span><i>Zip</i></span> </div>	
<b>Home Phone:</b> (____) _____ <b>Work:</b> (____) _____ ext: _____ <b>Cell:</b> (____) _____	
<b>Social Security #:</b> _____ <b>Date of Birth:</b> _____ <b>Marital Status:</b> <input type="checkbox"/> Married <input type="checkbox"/> Single <div style="text-align: right; margin-right: 100px;"><input type="checkbox"/> Other</div>	
<b>Employer or School:</b> _____	
<b>Employer Address:</b> _____ <div style="display: flex; justify-content: space-between; width: 80%; margin-left: 10px;"> <span><i>Street</i></span> <span><i>City, State</i></span> <span><i>Zip</i></span> </div>	
<b>EMERGENCY CONTACT - Name:</b> _____	
<b>Relationship:</b> _____ <b>Phone:</b> (____) _____	

<b>RESPONSIBLE PARTY</b>
<b>Name (Parent/Guardian/Other, who brought minor for therapy):</b> _____
<b>Date of Birth:</b> _____ <b>Social Security #:</b> _____
<b>Address:</b> _____ <div style="display: flex; justify-content: space-between; width: 80%; margin-left: 10px;"> <span><i>Street</i></span> <span><i>City, State</i></span> <span><i>Zip</i></span> </div>
<b>Home Phone:</b> (____) _____ <b>Work:</b> (____) _____ ext: _____ <b>Cell:</b> (____) _____

<b>INJURY INFORMATION</b>
Condition is related to: <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Home <input type="checkbox"/> Sports <input type="checkbox"/> Other <input type="checkbox"/> None
Is a home health agency currently providing nursing services in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No
How did you hear about us? _____
Have you had any therapy services in the last 12 months? YES or NO
If YES, where did you have the services: _____
Type of injury: _____
Referring Physician: _____ Referring Physician UPIN #: _____ <div style="text-align: center; font-size: small; margin-top: 5px;">(to be completed by Front Office Coordinator)</div>
Primary Care Physician: _____

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

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

**INSURANCE INFORMATION**

**Primary** Insurance Co.: \_\_\_\_\_

Ins. Phone #: (\_\_\_\_) \_\_\_\_\_

**Group #:** \_\_\_\_\_

**Policy I.D. #:** \_\_\_\_\_

Is patient the subscriber?  Yes  No

If **NO**, then:

Subscriber/Policyholder's Name: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_

Subscriber/Policyholder's Address: \_\_\_\_\_

*Street*

*City, State*

*Zip*

Relationship to Patient: \_\_\_\_\_

Subscriber/Policyholder's Date of Birth: \_\_\_\_\_

Subscriber/Policyholder's Social Security #: \_\_\_\_\_

Subscriber/Policyholder's Employer & Employer's Address: \_\_\_\_\_

**Secondary** Insurance Co.: \_\_\_\_\_

**Group #:** \_\_\_\_\_

**Policy I.D. #:** \_\_\_\_\_

Is patient the subscriber?  Yes  No

If **NO**, then

Subscriber's Name: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

Subscriber's Date of Birth: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Subscriber's Social Security #: \_\_\_\_\_

**AUTHORIZATION FOR DISCLOSURE**

I, a patient of The Morris Center for Sports Medicine, Inc, give my expressed permission to discuss with the individual(s) I have listed:

Please check appropriate box (es):

- Any aspect of my health care
- Health information only
- Financial information only

I understand that I am responsible for notifying this office, in writing, of any changes to this authorization to disclose my personal health information.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

A confidential message (i.e.: appointment reminders) may be left on your telephone answering machine or voicemail.

Please print the telephone number where you want to receive calls about your appointments or other health information other than your home phone:

(\_\_\_\_) \_\_\_\_\_

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

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

### INFORMED CONSENT

I consent to treatment rendered by The Morris Center for Sports Medicine, Inc. as ordered or approved by my physician. I agree to participate in The Morris Center for Sport's Medicine, Inc.'s program to the best of my ability to facilitate a rapid and full recovery.

I consent to having my picture taken for objective analysis of my condition. This information will be used solely for the purpose of education of myself for my condition and to compare pre and post treatment outcomes. Any other use of this information will require my written consent.

I understand that some increase in pain may be normal. I must determine how much pain increase is acceptable to me, and I may be asked to describe any pain using a Visual Analog Scale. I will not be asked to perform activities that increase my pain to a level that is unsafe or undesirable to me. I will be asked to perform activities, but will not be forced to perform any activity that I believe unsafe. I will be informed if I'm seen doing anything unsafe or that jeopardizes my recovery.

### CONSENT FOR RELEASE OF INFORMATION

Insurers may release to The Morris Center for Sport's Medicine, Inc. any information regarding the extent of my insurance coverage, information concerning the status of claims submitted by The Morris Center for Sports Medicine, Inc., and information regarding payments made directly to me on those claims. The Morris Center for Sports Medicine, Inc. may obtain any information and/or medical records pertinent to "treatment" provided from hospitals, physicians, nursing agencies, and other health care providers, Pursuant to the privacy rule 45CFR164.501 of HIPAA, "treatment" generally means the provision, coordination, or management of health care and related services among providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another.

### RECEIPT OF PRIVACY PRACTICE NOTICE

I understand that The Morris Center for Sports Medicine, Inc. has provided me with a copy of their Notice of Privacy Practices, which states how my personal health information (PHI) may be used or disclosed and outlines my rights regarding this information. I understand that The Morris Center for Sports Medicine, Inc. has the right to change this notice at any time and that I must request in writing any objections to any of these "uses" or "disclosure". I may obtain an additional copy of this notice from this office per my request.

**Please check one of the following statements:**

I received a copy of the Privacy Practices

I declined a copy of the Privacy Practices

### ASSIGNMENT OF BENEFITS

**I understand that I am ultimately responsible for the charges incurred for my services at The Morris Center for Sports Medicine, Inc. whether the benefits are through Commercial Insurance, Workers' Compensation or a Third-Party Payors (i.e.: auto accident).**

I also understand that additional information may be required of me to assist The Morris Center for Sports Medicine, Inc. in filing such claims. I may have to provide information from the following list regardless of my insurance:

- Social Security Number
- Date of Birth
- Copy of Insurance Card (for commercial filing and/or workers' compensation)
- Name of employer, Employer address, phone number and contact person
- Auto Insurance

**The Morris Center for Sports Medicine, Inc. will file my insurance claims as a courtesy, and understand that any quoted benefits given at the time of service are not a guarantee of payment. I assign all benefits paid by insurance to be paid directly to The Morris Center for Sports Medicine, Inc. By my signature below I acknowledge my responsibility and assign said benefits and verify that I have read and agree to the terms of The Morris Center for Sports Medicine, Inc. Payment Policy.**

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

**MEDICAL HISTORY QUESTIONNAIRE (PLEASE PRINT)**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Onset of Injury/Condition: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Have you had surgery for this injury? YES NO Type of surgery: \_\_\_\_\_

If you did have surgery, what was the date of the surgery? \_\_\_\_\_

Have you had previous physical therapy for this condition? YES NO

List ALL medication(s) you are allergic to: \_\_\_\_\_

- Do you have any sensitivity to latex that you are aware of? YES NO

List medications that you are currently taking, either prescription or non-prescription: \_\_\_\_\_

Do you smoke? YES NO Are you currently pregnant or think you might be pregnant? YES NO

Please list any other health care professionals whose care you are currently under for this condition: \_\_\_\_\_

**HAVE YOU EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS?**

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Infectious Diseases
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain or Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Heart Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Headaches Frequent/Severe
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Hearing/Vision Difficulties
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or Tingling
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Stroke or TIA	<input type="checkbox"/>	<input type="checkbox"/>	Weakness
<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Disease			
<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots			
<input type="checkbox"/>	<input type="checkbox"/>	Circulation Problems			
<input type="checkbox"/>	<input type="checkbox"/>	Seizure Disorder or Epilepsy			
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems			
<input type="checkbox"/>	<input type="checkbox"/>	Asthma, Emphysema or Bronchitis			
<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency			
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes			
<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis			
<input type="checkbox"/>	<input type="checkbox"/>	Other Arthritis Conditions			
<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia			

**Surgery or Injury of any of the following:**

Neck-Type: \_\_\_\_\_

Back-Type: \_\_\_\_\_

Shoulder-Type: \_\_\_\_\_

Elbow-type: \_\_\_\_\_

Hand-Type: \_\_\_\_\_

Hip-Type: \_\_\_\_\_

Knee-Type: \_\_\_\_\_

Ankle or Foot-Type: \_\_\_\_\_

How has your injury affected you emotionally? Depression  Withdrawal  Anger  Anxiety  Other   
None

What is the severity of your emotional reaction? Scale of 1(low) – 10 (high) \_\_\_\_\_

Who is your family/community support? \_\_\_\_\_

Is there any other information that would assist us with your care? \_\_\_\_\_

**PATIENT/GUARDIAN**

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

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

**THERAPIST**

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

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

THE MORRIS CENTER

**Cancellation / No-show Policy**

We strive to provide not simply good, but absolutely the best care to our clients. We schedule our clients according to care plans that optimize their wellness outcomes. Making your appointment as scheduled is very important, not just for us, but for you. We are convinced that if you make your wellness a life priority, you will achieve not only a higher level of function, but a greater degree of happiness.

We have the most highly trained and experienced clinicians in the region. You are working with the best. Their services and time are in high demand, with waiting lists for many of their services. As you know, we attempt to schedule all new clients within 24-48 hours of their initial request for service. Thus, appointment time is a valuable commodity for both you and us.

*If negative circumstances require you to cancel a scheduled appointment, we request that you do so at least 48 hours in advance. If you must cancel within 24 hours of your appointment or fail to show up for your appointment, a \$20 fee will be applied to your account, which will be patient responsibility and is not billable to insurance. This facility also reserves the right to cease rescheduling new appointments due to habitual no shows or cancellations and reserves the right to discharge any patient who fails to give proper notice three consecutive times.*

While we are not fond of the negative connotation of any cancellation policy, we believe such a policy is in the best interest of accommodating all of our clients who are dedicated to improving their wellbeing. Thank you for your consideration.

By signing below, I understand and accept the above cancellation / no-show policy.

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NAME

DATE



## Notice of Privacy Practices

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

Protected health information about you is maintained as a record of your contacts or visits for healthcare services with our clinics. Specifically, "protected health information" is information about you, including name, address, phone, etc. that may identify you and relates to your past, present or future physical health condition and related health care services.

We are required to follow specific rules on maintaining the confidentiality of your protected health information, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This notice describes your rights to access and control your protected health information. It also describes how we follow applicable rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations and of other purposes that are permitted or required by law. If you have any questions about this notice, please contact our Account Representative.

### **Your Rights Under The Privacy Rule**

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with our staff.

**You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices** – We are required to follow the terms of this notice. We reserve the right to change the terms of our notice at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

**You have the right to authorize other use and disclosure** – You have the right to authorize or deny any other use or disclosure of protected health information that is not specified within this notice. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

**You have the right to designate a personal representative** – You may designate a person with the delegated authority to consent to or authorize the use or disclosure of protected health information.

**You have the right to inspect and copy your protected health information** – You may inspect and obtain a copy of protected health information about you that is contained in your patient records.

**You have the right to request a restriction of your protected health information** – You may ask us, in writing, not to use or disclose and part of your protected health information for the purposes 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 for notification purposes as described in this Notice of Privacy Practices. In certain cases, we may deny your request for a restriction.

**You have the right to request an amendment to your protected health information** – You may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.

**You have the right to request disclosure accountability** – You may request a listing of disclosures that we have made of your protected health information to entities or persons outside of our office other than for the purposes of treatment, payment, healthcare operations, or a purpose authorized by you.

### **How We May Use or Disclose Protected Health Information**

Following are examples of uses and disclosures of your protected health care information that we are permitted to make.

**Treatment** – We may 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 that is involved in your care and treatment. We may disclose protected health information to other healthcare providers who may be involved in your care and treatment. We may also call you by name in the waiting room when your healthcare provider is ready to see you. We may use or disclose your protected health information as necessary to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or treatments and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health related benefits and services offered by our office.

**Payment** – Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

**Healthcare Operations** – We may use or disclose, as needed, your protected health information in order to support the business activities of our practice. This includes, but is not limited to, business planning and development, quality assessment and improvement, medical review, legal services, and auditing functions. It also includes education, provider credentialing, certification, underwriting, rating, or other insurance-related activities. Additionally, it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-identified information.

## **Other Permitted and Required Uses and Disclosures**

We may also use and disclose your protected health information in the following instances as outlined below. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

**To Others Involved in Your Healthcare** – Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, **you identify**, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

**As Required By Law** – We may use or disclose your protected health information to the extent that the law requires the use or disclosure.

**For Public Health** - We may use or disclose your protected health information for public health activities and purposes to a health authority that is permitted by law to collect or receive the information.

**For Communicable Diseases** – We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

**For Health Oversight** – We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

**In Cases of Abuse or Neglect** – We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made in a manner that is consistent with the requirements of applicable federal and state laws.

**To The Food and Drug Administration** – products: to enable product recalls; to make repairs or replacements, or to conduct post-marketing surveillance, as required.

**For Legal Proceedings** – We may disclose protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

**To Law Enforcement** – We may also disclose protected health information as long as applicable legal requirements are met for law enforcement purposes.

**In Cases of Criminal Activity** – Consistent with applicable federal and state laws, we may disclose protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

**For Military Activity and National Security** – When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel: 1) for activities deemed necessary by appropriate military command authorities; 2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or 3) to foreign military authority if you are a member of that foreign military service.

**For Worker's Compensation** – We may disclose your protected health information, as authorized to comply with worker's compensation laws and other similar legally established programs.

**When an Inmate** – We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

**Required Uses and Disclosures** – Under the law, we must make disclosures about 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 the Privacy Rule.

**Complaints** -You may address complaints 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 Account Representative of your complaint.

## The Morris Center for Sports Medicine, Inc.

### PAYMENT POLICY

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#### ***We want to help you.***

In an ongoing effort to better serve our patients, The Morris Center will use reasonable efforts to obtain benefit information from your insurance carrier for outpatient rehabilitation services.

**Because your insurance carrier typically does not guarantee either the benefits it provides to us on your behalf, or the payment for services rendered to you, your carrier's benefit information we provide to you may not be completely accurate. We will not know exactly what your coverage of expenses will be until we have received reimbursement from your insurance carrier at which time you are responsible for the balance of all unpaid claims.**

#### ***We will file your insurance claims for you.***

The Morris Center wishes to make payment for your account balance as convenient for you as possible. Insurance companies require the separate filing of our professional fees for each date of service. As a courtesy to you, we customarily file your claims with your insurance company. **Each patient, however, remains fully responsible for the entire amount of the bill until all claims are paid.**

#### ***What type of payment is expected at time of service with The Morris Center?***

Payment for any deductible or co-payment is expected at the time of your visit. If our staff is unable to confirm that you have insurance coverage, payment of your charges in full is requested at time of service. Any payment due may be made by cash, personal check, money order, Visa, or MasterCard. If the patient balance exceeds 30 days with The Morris Center, the unpaid balance is subject to a 1.5% finance charge each month, 18% annually.

#### ***What if you are unable to comply with our payment policy?***

Arrangements must be made with the site manager or billing department.

#### ***Any questions?***

If you have questions concerning our billing and payment policy, please contact the corporate billing office at 812-476-7000, and we will be happy to assist you.

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#### **Overdue account balances**

*It is unpleasant when no arrangement for payment can be made or agreed-upon payments arrangements become delinquent. Any account may be considered a bad debt risk if it becomes 90 days past due. When this happens, we may have no recourse but to assign your account to a third party collection agency for collection or place your account with an attorney to obtain judgment or otherwise satisfy payment of the delinquent account. If this occurs, a collection fee of up to 30 percent of the unpaid balance may be added to your account. We may also charge reasonable attorney fees, court costs, interest, late fees, sheriff's fees, and similar fees.*