SEVILLE PHYSICAL THERAPY LLC

REGISTRATION FORM

Please provide the following information and answer the questions below. Note that information you provide here is protected as confidential information.

Name:_____

Date of Birth:_____ Age: _____ SSN:_____

Street address: _____

City: _____ State:_____ Zip Code:_____

Marital Status: ___Single ___Married ___Divorced ___Widowed/ _____

Work Status: ___Currently employed ___Retired ___Student ___Disabled

Occupation: _____ _____ Full time or ___ Part time

Home Phone #:_____ Cell #:_____

Appointment Reminders by text:_____ OR Prefers Voice Call Reminders: _____

Best Email Address: _____

OK to send correspondence/updates/newsletter by Email: _____Yes _____ No

Patient signature approving ways of communication indicated above.

Note: You can change/cancel anytime: (Sign & date) _____

OK to have picture/s taken for Evaluation & Treatment: _____Yes _____No

Emergency Contact Person: _____

Relationship & Phone Number:_____

How did you hear about us (Personal, website, other)?_____

_____

Primary Physician or Referring Physician: _____

Address: _____

Phone/Fax Number:_____

CONSENT FOR TREATMENT

I hereby grant Seville Physical Therapy, LLC, the authority to evaluate and treat me or my dependent and order the examination, tests, treatments and other clinical services necessary for my care and treatment.

Seville Physical Therapy, LLC is a direct hands-on Physical Therapy clinic. Though highly specialized, treatment consists primarily of manual therapy techniques and treatment forms that are published or otherwise publicly known. Forms of deep tissue massage, with or without using an instrument, therapeutic exercise programs, gait training, neuromuscular re-education, cranio-sacral therapy, myofascial release, bone and soft tissue manipulation, visceral manipulation as well as other treatment modalities may be used.

Some of the hands-on treatment techniques require deep pressure which may cause bruising and periods of increased soreness which may last from 1-72 hours. Symptoms may also change and move to other parts of the body. This is not unusual and is rarely a concern, however, please ask if you have any concerns or questions.

The number of treatments needed and recovery time can vary widely due to the duration of the problem, history of repeated episodes in the past, patient age and many other contributing factors.

I have read and fully understand the above statements. I understand the nature of the treatments at Seville Physical Therapy, LLC and I authorize the fully trained staff to use treatment techniques as deemed necessary for my safe and effective recovery.

_____ _____

Signature of Patient Date

_____ _____

Authorized Representative Date
(Indicate the Relationship)

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

This authorization complies with 45 CFR § 164.508(c) (HIPAA)

Patient: _____ **Date of Birth**_____

I hereby authorize SEVILLE PHYSICAL THERAPY, LLC to furnish, discuss and release all information and records requested below, in writing, covering findings, treatment rendered, and opinions as to my condition as authorized below.

Dates of Records to be released: from _____

and for the next 12 months or until I revoke this Authorization, whichever comes first.

Purpose of this Authorization to Release Health Care Information:

−to develop and coordinate my treatment plan

−to communicate contraindications, precautions, progress and/or recommendations for return to work, athletic/sports activities or other functional activities

−to pursue legal/liability claims

Other: _____

Records authorized to be released:

−Examination/Evaluation records

−All treatment records

−Diagnostic tests (MRI, X-rays, CT Scan, EMG/NCV testing, and any other diagnostic tests) in my records regardless of who created the records.

Other: _____

I UNDERSTAND:

- I understand, and voluntarily consent, to disclosure of information to the extent stated above. A copy of this Authorization shall have the same force and effect as the original. Subsequent disclosures may be made under this Authorization.
- I may refuse to authorize disclosure of health care information, and if I refuse or if I revoke the Authorization, I understand that such refusal or revocation my result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance coverage or benefits, or other adverse consequences. Further, I understand that such revocation may be the basis for denial of health care benefits or other insurance coverage or benefits.
- The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
- I may revoke this authorization at any time by executing a written revocation, subject to the rights of any individual who acted in reliance on the authorization prior to receiving notice of revocation. This revocation will be signed and dated by me and will state that all or part of this authorization is revoked.
- Upon my request, I am entitled to inspect or copy information disclosed hereunder, pursuant to C.F.R. 164.524.
- I understand that treatment will not be denied if I refuse to sign this authorization.
- This Authorization to obtain/release records will be effective until revoked in writing by me or for 12 months from the date hereby signed, whichever comes first.
- No enrollment or eligibility for benefits, treatment or payment is intended or expected to be conditioned upon this Authorization.

_____ _____

Patient's Signature Date

_____ _____

Parent/Guardian's Signature Date

OFFICE POLICIES, PROCEDURES AND AUTHORIZATIONS

Welcome and thank you for choosing Seville Physical Therapy for your physical therapy needs.

CANCELLATION POLICY

As a courtesy to other patients trying to get scheduled and our Therapists, we require a 24-hour (or greater) notice for cancellations. This allows others on waiting lists to be seen. When you make an appointment, that time is reserved for you. You are asked to pay the cancellation fee of $100. per missed appointment and for appointments cancelled within 24 hours of your scheduled time. Only emergencies or illnesses are excusable.

Insurance Authorization Out of Network

To further assist me in securing reimbursement from my insurance company, I hereby authorize Seville Physical Therapy, LLC to furnish the insurance carrier with information concerning my illness and treatment. I also authorize electronic transmission of my insurance claim to the carrier.

Consent to Electronically Transmit (FAX)

I hereby authorize Seville Physical Therapy, LLC permission to electronically transmit (FAX) copies of medical records or patient information to any and all referring physicians, hospital, auxiliary services referred by this practice or firms that have been your representative. It is my understanding that there are instances when electronically transmitted information may go somewhere other than the destination number due to technological malfunctions and Seville Physical Therapy will not be held responsible.

Patient Rights

I realize I have the right to refuse any drugs, treatments or 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.

The State of New Jersey allows you to see a physical therapist directly without seeing a doctor. Seville Physical Therapy will send a plan of care to your physician informing them that you are receiving physical therapy from us. If after 30 days or the 10th visit whichever comes sooner and you have not made progress from physical therapy, we will refer you to another medical professional like a specialist or your primary MD to get further help.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE WRITTEN STATEMENTS. ANY QUESTIONS I MAY HAVE HAD, HAVE BEEN ANSWERED TO MY SATISFACTION.

_____ Date: _____

Signature of Patient/Legal Guardian

Name of Patient (please print) : _____

PAYMENT AGREEMENT

Thank you for choosing Seville Physical Therapy, LLC as your physical therapy provider. Before we begin services, please sign below indicating that you have read, understand and agree to the following payment policies:

- Payment is expected at time of service unless we are in-network with or agree to accept assignment from your health plan or other responsible payor and you authorize the assignment or you have made other payment arrangements with us.
- You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.
- Out-of-Network Policy. (Does not apply to Medicare)

  If we are out-of-network with your health plan and you have out-of-network benefits, upon your request, we can provide you the invoice so you can submit the bill to your insurance company and you will just pay Seville Physical Therapy the charges upfront. We can assist to verify your benefits and will obtain any required authorizations by your insurance policy. If you decide not to submit the claim yourself, we can also submit as an out of network provider and we will be the one to collect the reimbursements. However, if insurance denies coverage and payments, you will be responsible for the charges of the services provided that is not covered by your policy and also for the balance if the insurance reimbursement is inadequate. You are also responsible for a deductible that is not met during your covered policy period. We will collect payment for services upon notification from insurance for non-payment or inadequate payment.
- For Insurance Companies that send the insurance reimbursement directly to the member, we request that you endorse and forward the checks to Seville Physical Therapy within a week of receipt in order that Seville Physical Therapy will reconcile the reimbursements and payments, if any, had been made beforehand. You agree to provide a credit card on file that will be charged if insurance checks received by the client are not endorsed in a timely manner and also to cover charges in the event of an insurance denial or inadequate payment.
- Medicare Policy. We are enrolled as a participating provider with Medicare. As such, our charges for Medicare covered benefits are limited to Medicare's fee schedule for participating providers. Medicare's fee schedule only applies to the services that meet all of Medicare's Conditions for Payment and Medicare pays for the service. You understand and agree that you have been fully informed in advance about what interventions and/or services, if any, are not covered by Medicare and therefore not subject to Medicare's fee schedule for participating providers and have agreed to pay our charges for those services. This includes services which are not paid by Medicare because the service is not covered, not Medically necessary or in excess of Medicare's annual therapy cap.

(Payment Agreement continued on page 6)

- Appeals Policy. You understand that you are responsible for filing all appeals of adverse benefit determinations. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.
- Collection Policy. You understand that we are not required to obtain your written authorization to disclose protected health information to a collection agency or court of law that may be necessary to collect payment for services rendered. Should collection proceedings or other legal action become necessary to collect an overdue account, you will be responsible for paying the collection costs plus court costs and filing fees incurred by the practice.

<u>Assignment of Benefits and Authorized Representative Appointment</u>

- Assignment of Benefits. I hereby assign and convey directly to Provider all health plan benefits and/or insurance reimbursement benefits (including MedPay and/or Personal Injury Protection benefits), if any, otherwise payable to me for medical services, treatments, therapies and/or examinations rendered or provided by Provider regardless of its managed care network participation status. I also hereby assign and convey any and all rights under ERISA and any other applicable state and federal laws to pursue payment for Provider's services until Provider's claims are paid in full, including but not limited to legally required notices and procedural reviews concerning my benefits and filing a civil action in federal court. I understand that I will no longer be entitled to said rights. I also understand that I may revoke this assignment at any time by sending written notice to the Provider and my health plan. l hereby authorize Provider to release all medical information necessary to process my claims to the responsible Payor. I agree that if any payments are sent to me despite my assignment of benefits to Provider, I will promptly forward the funds and explanation of benefits/payment to Provider.

I HAVE READ, I UNDERSTAND AND I AGREE TO THESE PAYMENT TERMS AND ASSIGNMENT OF BENEFITS.

X _____ Date: _____

Signature of Patient and/or Guardian

X_____ Date: _____

Signature of Provider Representative

A photocopy of this agreement is to be considered valid, the same as if it was the original.

INSURANCE PARTICIPATION STATUS AND FEES DISCLOSURE FORM

SEVILLE PHYSICAL THERAPY, LLC

Under the New Jersey "Out-of-network Consumer Protection, Transparency, Costs Containment and Accountability Act", P.L.2018,c.32 (the "Act"), health care providers and health care facilities are required to disclose to "covered persons" (a person on whose behalf a carrier is obligated to pay health care expense benefits or provide health care services) the health benefits plans in which the health care provider participates as well as the health care facilities with which the health care provider is affiliated. Therefore, please be advised that **SEVILLE PHYSICAL THERAPY, LLC** (the "Practice") is disclosing the following to the patient _____(or the patient's parent or legal guardian as set forth at the end of this Disclosure Form) (the "Patient"):

Facilities the Practice is Associated with and Address(es):
82 NORTH SUMMIT ST, SUITE D
TENAFLY, NJ 07670

Licensed Healthcare Staff:

The following licensed healthcare professionals may perform assistant services to the Patient based upon the Patient's treatment plan and needs as determined by the Practice:

PURISSA SEVILLE, RPT, CMTPT, MDT

Health Benefits Plans The Practice Participates With:
MEDICARE ONLY. OUT OF NETWORK WITH ALL OTHER HEALTH INSURANCES.

If the Patient's health benefits plan is not listed above, the Practice (and potentially the health care facilities listed above, if any) do not participate with the Patient's health benefits plan. In order to proceed with any such services for which the Practice is out-of-network with the Patient's health benefits plan, the Patient hereby acknowledges and agrees:

1) The Patient understands that the Practice (and all of its licensed health care professionals) that the Patient is seeking healthcare services from is out-of-network with and does not participate with the Patient's health benefits plan;
2) The Patient understands that the amount or estimated amount the Practice will bill the Patient for the services is available upon request;

3) The Patient understands that the Patient may request from the Practice an estimated charge for the services proposed and the Current Procedural Terminology (CPT) codes associated with that service, and the Practice will disclose to the Patient, in writing, the amount or estimated amount that the health care professional will bill the Patient for the service, and the CPT codes associated with that service, absent unforeseen medical circumstances that may arise when the health care service is provided;
4) The Patient understands that the Patient will have a financial responsibility applicable to health care services provided by an out-of-network professional, in excess of the Patient's in network copayment, deductible, or coinsurance, and that the Patient may be responsible for any costs in excess of those allowed by the Patient's health benefits plan.
5) The Patient has been advised that the Patient should contact the Patient's health benefits plan or administrator for further consultation on those costs.

The Practice and Patient both acknowledge and agree that receipt or acknowledgement by Patient of these disclosures shall not waive or otherwise affect any protection under existing statutes or regulations regarding in network health benefits plan coverage available to the Patient under the law.

The Practice further acknowledges and agrees that if, between the time these disclosures are made to the patient and the time the health care service takes place, the network status of any of the Practice changes as it relates to the Patient's health benefits plan, the Practice shall notify the Patient promptly.

Acknowledgement of Receipt of Disclosure Form

I, the undersigned Patient (or the Patient's parent or legal guardian), acknowledge receipt of this Disclosure Form from the Practice, have read it and understand the above provisions. I have discussed my option to obtain treatment with other health care providers or at alternative health care facilities that may participate with my health benefits plan and I waive the right to do so and wish to obtain my treatment at the Practice with full notice of the above disclosures and potential costs that going to an out-of-network provider such as the Practice.

By: _____ Date: _____

Print Name of Patient: _____
If signing on behalf of the Patient indicate whether a parent or legal guardian of the Patient

SEVILLE PHYSICAL THERAPY, LLC
82 North Summit St., Suite D,
Tenafly, NJ 07670
201-537-4888

CORONAVIRUS 2019 QUESTIONNAIRE

This Information is Highly Confidential and will be securely managed.

Name: _____ Date: _____

Date of Birth: _____ Signature: _____

You will be asked to complete this form at each visit or to verbally confirm that there have been no changes in your answers since the initial form completion.

Please **choose Yes** or **No.** Feel free to explain what a yes or no answer means in the Comment Section below the question.

1. Have you been in close contact, in the past 30 days, with an individual who has/had any of these symptoms? Yes No

Fever over 100.4°F
Persistent cough
Shortness of breath
Diminished sense of smell and/or taste

If yes, have they been diagnosed and/or seen the doctor? Yes No
Comment: _____

2. Have you had any of these symptoms? Yes No

Fever over 100.4°F
Persistent cough
Shortness of breath
Diminished sense of smell and/or taste
If yes, how long have you had these symptoms? _____
If yes, have you been diagnosed and/or seen the doctor? Yes No
Comment:_____

If you answered yes to any of the questions above, we will work with you to make accommodations for therapy to the best of our ability. Thank you for assisting us in our endeavors to minimize exposure to the Coronavirus 2019.