Physical Medicine & Rehabilitation Clinic of St. Louis
James L. Williams, MD
121 St. Luke's Center Dr., Bldg. A, Ste. 500
Chesterfield, MO 63017
Office: (314) 205-6503 Fax: (314) 205-6509
www.pmrstl.com

*Welcome to Physical Medicine & Rehabilitation Clinic of St. Louis. We are happy you have chosen us to care for you.*

We realize your time is valuable. We do the best we can to be punctual and minimize your wait to be seen. However, we cannot always anticipate the complexity of every patient's condition. In order to provide the best possible care to every patient, we will occasionally run over the alloted amount of time for a particular appointment. If you have to wait to be seen, please keep this in mind and we will do everything we can to make your time with us comfortable.

*Physical Medicine & Rehabilitation Clinic of St. Louis complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.*

## Appointments

In an effort to keep the office running smoothly and decrease wait times, we ask that **you arrive one-half hour (30 minutes) before the scheduled time of your appointment**.
Please complete the new patient registration and medical history forms and bring with you to your first visit.

**If you have access to a fax machine, we request that you fax the completed new patient paperwork to our secure fax # (314) 205-6509.**

* *Note: If faxed, you will then need to arrive 15 minutes prior to your scheduled appointment time, not 30 minutes prior.*

For every appointment bring with you:
Insurance card(s)
Insurance referral if required
Driver's license or other form of picture ID
Copay/ Deductible/ Co-insurance amounts determined by your insurance to be your responsibility are due at the time of service

- We accept Cash, Check, Visa, MasterCard, Discover and American Express

**Treatment Disclosure** A copy of your visit note will be sent to the referring physician. As a courtesy, a copy will also be sent to your primary care physician unless you object.

## Medical Records

As a consultant, it is very important that all prior treatment records are received in our office before your appointment time.
Please notify the physician who referred you of your scheduled appointment date & request any related treatment notes be sent prior to your appointment.

## Page 2 - Medical Record Authorization to Disclose: *(To be used in our office at the time of your visit)*

1) Please Sign the Authorization for Disclosure of Personal Health Records *(signature field found at the bottom of the page)*
2) While you are being treated, *we will complete the top portion of the form* & request treatment records not already received, from any providers/medical specialists who have treated you in the past for the condition/injury that you are being seen for.
   - Please leave blank the Authorization fields. (I HEREBY AUTHORIZE _____).

## Page 2 - Requesting your Medical Records from Other Specialists:

1) You may also copy and use this form to have all treating physicians/specialists records sent to us before your scheduled visit.
2) Complete ALL sections of this form if YOU are requesting records be sent from another provider- including what specific records to send to our practice *(ex: all visit notes within a date range of xx/xx/xx to xx/xx/xx or specific lab or test report*)

*It is NOT necessary to request records if:*

- we are already in possession of those treatment records
- the referring physician has already sent or told you they will send the records
- a worker's compensation case manager is sending the records
- It is not necessary to request treatment notes that are not related to your scheduled appointment.

## Medical History Sections titled: ALLERGIES, MEDICATIONS, PAST MEDICAL HISTORY, SURGERIES

For your convenience, instead of completing these sections by hand, we will make a copy of any list you bring with you that includes that information *Examples: List of your current medications including dosage / List of Past Surgeries -

## X-Ray, MRI, CT

Please bring the actual films or studies that we will need to assess your condition. Any copies of films you bring, you will take home and keep for your personal records.

- Please let us know if films or studies were performed at -
  *St. Luke's Hospital, CDI, Barnes Jewish Hospitals, Missouri Baptist, SSM or Metro Imaging,*
  We may be able to view those films online and it may not be necessary for you to bring the actual films or studies.

**If you have any questions please feel free to contact us at (314) 205-6503.**

## AUTHORIZATION FOR THE DISCLOSURE OF PERSONAL HEALTH RECORDS

(Required by the Health Insurance Portability and Accountability Act – 45 CFR Parts 160 and 164)

Person's First:` _____ Person's Last Name:_____

Birth Date: _____

Street Address: _____

City:_____ State: _____ Zip Code: _____

**I HEREBY AUTHORIZE:**

Person or Organization:_____

Address: _____

**To Disclose My Personal Health Information To:** **James L. Williams, MD**

Physical Medicine & Rehabilitation Clinic of St. Louis
Office: (314) 205-6503 / Fax: (314) 205-6509
121 St. Luke's Center Dr., Bldg. A #500
Chesterfield, MO 63017

**INFORMATION TO RELEASE:**

(The medical records to be released may contain general medical information pertaining to mental health services, drug and/or alcohol diagnosis and treatment, HIV / AIDS testing, HIV / AIDS results or HIV / AIDS information).

☐ Complete Health Record

☐ Health Record as requested **BELOW:** (check all that apply)

☐ Complete Health Record: Limited to dates of service from _____to _____

☐ Health Record Limited- For Condition(s) Related To: _____

☐ For dates of service from: _____to _____

☐ ALL Dates

☐ Lab(s):_____ ☐Radiology:_____

☐ Other:_____

**ADDITIONAL AUTHORIZATION TO RELEASE INFORMATION**

*(Except for general information included in your health record as requested above, this information will not be released unless the appropriate box is checked)*

(*) If Checked, This release also specifically allows the release of the following information regarding the diagnosis, treatment & other information related to your treatment. *Such notes may contain general information on medical care; alcohol & drug abuse treatment; mental health treatment; (HIV) (AIDS);communicable diseases or infections; demographic information*

☐ Any record of treatment for Drug and/or Alcohol dependency or abuse;
☐ Any record of Mental Health treatment
☐ Any record of Psychotherapy Notes
☐ Any record of testing, care, treatment, reporting or research pertaining to infection with HIV
☐ Any record of testing, care, treatment, reporting pertaining to STD or communicable diseases

**REASON FOR RELEASE:**

☐ Workers Compensation ☐ Treatment/Consultation Purposes ☐ Transfer of Care

☐ Other (specify):_____

**CONSENT:**

- I understand that my health record may include ***general*** information related to my mental health, drug/alcohol abuse, sexually transmitted diseases, and other information that I may consider sensitive.
- Protected Health Information, once it is used or disclosed pursuant to the authorization has the potential to be re-disclosed and no longer be protected by the Privacy Regulations.
- I understand that this authorization pertains to information obtained prior to the date that I signed.
- I understand this authorization is voluntary. I do not have to sign to assure treatment unless the sole purpose of treatment is to provide information to a third party.
- I understand I have the right to revoke authorization at any time by presenting a written request to the medical records department at the address on this form.
- I understand I may request a copy of this signed authorization.
- I understand I cannot revoke this authorization once the covered entity has taken action to release the records upon reliance of this authorization.
- This authorization is valid for **90 days** from the date signed unless expressly revoked at an earlier time
- I understand a photocopy of this authorization is valid as the original

**Signature** of Person, Parent, or Legal Representative: _____**Date**: _____

Your Relationship to the Patient: ☐ Self ☐ Other: _____

## Patient Information

Last Name:_____ First Name_____ MI:_____Date of Birth:_____

Social Security #:_____ Sex: ☐ Male ☐ Female Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Address: _____Apt #: _____

City:_____ State:_____ Zipcode:_____

☐ Home Phone:_____ ☐ Work Phone:_____ ☐ Cell: _____

** Please Check ☒ the preferred phone # we may reach you at*

Email: _____

Employer:_____ Employer Address:_____ Employer Phone _____

Race: ☐ Decline to Answer ☐ White ☐ Black/African American ☐ American Indian/Alaskan ☐ Asian ☐ Native Hawaiian/Pacific Islander

Ethnic Background ☐ Decline to Answer ☐ Hispanic or Latino ☐ Not Hispanic or Latino Preferred Language: ☐English ☐Other:_____

## Spouse / Parent / Guardian Information

Name:_____ Date of Birth:_____

**Relationship to Patient** ☐ Spouse ☐ Parent ☐ Child ☐ Other:_____ ☐ Legal Guardian ☐ Legal Guardian/Attorney

Social Security #:_____

Address:_____ Apt #:_____City:_____ State:_____ Zip:_____

☐ Home Phone: _____ ☐ Work Phone:_____ ☐ Cell: _____

*** Please Check (X) the preferred phone # we may reach you at ***

Employer:_____Employer Address:_____Employer Phone_____

☐ I authorize Physical Medicine & Rehabilitation Clinic of St. Louis to discuss my medical treatment with this person

## Pharmacy Name:_____ Phone #:_____ Fax #:_____

Street/Cross Streets: _____City: _____State:_____ Zip: _____

## Emergency Contact (friend or relative not living with you) Relationship To You: _____

Name:_____Home Phone:_____Cell Phone:_____

Address: _____ City: _____State:_____ Zip: _____

☐ I authorize Physical Medicine & Rehabilitation Clinic of St. Louis to discuss my medical treatment with this person

**Who May We Thank for this Referral?** ☐ Doctor ☐ Insurance ☐ Friend ☐ Relative ☐ Self ☐Other _____

Name:_____ Phone #:_____ Fax #: _____

Address: _____City: _____State:_____ Zip: _____

## Primary Care Physician Name:_____ Phone #:_____

Address: _____

- To promote comprehensive patient care, we communicate our findings & impressions not only with you, our patient, but also with appropriate referring physicians, primary care physicians, any party involved in the workers' compensation proceedings. and other providers when indicated.

## Insurance Information- *(please select PLAN TYPE)* →*:* ☐ WORKERS COMPENSATION CLAIM ☐ ACCIDENT CLAIM (MVA /OTHER)

☐ EMPLOYER PLAN ☐ RETIREE / "OTHER" PLAN ☐ SELF INSURED ☐ MARKETPLACE PLAN ☐ MARKETPLACE -SUBSIDIZED PLAN

**PRIMARY Insurance Company**: _____

Name of Insured/Subscriber:_____ Date of Birth:_____

Patient's Relationship to Insured: ☐ Self ☐ Spouse☐ Child ☐ Other:_____

**SECONDARY Insurance Company:** _____

Name of Insured/Subscriber:_____ Date of Birth:_____

Patient's Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:_____

Name: _____ **DATE** Form **Completed**:_____

**ALLERGIES:** List ALL medication allergies: (*include* allergic reaction)

☐ **N**o **K**nown **A**llergies ☐ See **S**eparate **L**ist - **A**ttached

☐ Penicillin /Reaction:_____ ☐ Sulfa /Reaction:_____ ☐ Codeine /Reaction:_____

☐ Latex/Reaction:_____ ☐ Other(s):_____ /Reaction:_____

☐ Other(s):_____/Reaction:_____

☐ Other(s):_____/Reaction:_____

**MEDICATIONS:** List ALL medications taken -include over the counter medications (*attach a separate list for additional medications)*:

☐ **N**o Current Medications ☐ See **S**eparate **L**ist - **A**ttached

_____ Strength/Dose:_____ How Often Taken:_____

_____ Strength/Dose:_____ How Often Taken:_____

_____ Strength/Dose:_____ How Often Taken:_____

_____ Strength/Dose:_____ How Often Taken:_____

_____ Strength/Dose:_____ How Often Taken:_____

_____ Strength/Dose:_____ How Often Taken:_____

_____ Strength/Dose:_____ How Often Taken:_____

**Review of Systems** **please ☒ mark symptoms** in the list below that applies to you

**Constitutional**: ☐ chills, ☐ fatigue, ☐ fever, ☐ night sweats, ☐ weight gain, ☐ weight loss, ☐ victim of domestic violence or assault

**Eyes:** ☐ blurry vision, ☐ eye pain, ☐ sensitivity to light

**Ear, Nose, Throat:** ☐ hearing problems, ☐ ringing in ears, ☐ ear pain, ☐ nosebleeds

**Cardiovascular:** ☐ chest pain/angina, ☐ calf pain-when walking, ☐ dizziness, ☐ shortness of breath-while lying down, ☐ palpitations, ☐ waking up short of breath, ☐ leg swelling, ☐ fast heart rate, ☐ varicose veins

**Respiratory:** ☐ cough-acute, ☐cough-chronic, ☐ difficulty breathing, ☐ exposure to TB, ☐ coughing up blood, ☐ wheezing

**GI tract:** ☐ abdominal pain, ☐ heartburn, ☐ anorexia, ☐ bloating, ☐ difficulty swallowing, ☐ diarrhea, ☐ constipation, ☐ vomiting blood, ☐ rectal bleeding/blood in stool, ☐ hemorrhoids, ☐ dark/tarry stool, ☐ nausea, ☐ vomiting, ☐ pain when swallowing, ☐ stool caliber (width/shape) change

**GU tracts:** ☐ painful urination, ☐ blood in urine, ☐ frequent urination, ☐ frequent urination at night, ☐ loss of control of urine

**FEMALE** – ☐ painful menstruation, ☐ heavy menstruation, ☐ irregular menstrual cycle, ☐ pain with sex, ☐ history of abuse or assault

**MALE** ☐ impotence, ☐ history of abuse or assault

**Musculoskeletal:** ☐ severe joint pain, ☐ back pain, ☐ joint stiffness, ☐ limb pain (hand,arm,foot,leg), ☐ severe muscle pain

**Skin:** ☐ atypical mole (s), hives

**Neurological:** ☐ unsteady gait, ☐ dizziness, ☐ fainting, ☐ headaches, ☐ memory loss, ☐ burning/prickling/tickling/ tingling, or numbness sensations, ☐ seizures, ☐ tremor, ☐ weakness

**Hematologic/Lymphatic:** ☐ easy bruising, ☐ excessive bleeding

**Endocrine:** ☐ enlarging hands or feet, ☐ hair loss, ☐ problems with hot or cold temperatures, ☐ excessive facial/body hair, ☐ hot flashes, ☐ increased skin pigmentation, ☐ infertility, ☐ excessive thirst, ☐ excessive hunger, ☐ stretch marks, ☐ excessive sweating

**Psychiatric:** ☐ anxiety, ☐ crying spells, ☐ depression, ☐ feeling stressed, ☐ loss of interest in pleasurable activities, ☐ mood swings, ☐ personality change, ☐ PMS, ☐ poor concentration, ☐ recreational drug use, ☐ sadness, ☐ sleep disturbance, ☐ suicidal thoughts

Name:_____ **DATE** Form **Completed**:_____

## Past Medical History

Do you have or have you ever had: ☒ please checkmark

| | | |
|---|---|---|
| ☐ High Blood Pressure | ☐ CAD (Coronary Artery Disease) | ☐ Arrhythmia (example: AFib, Tachycardia) |
| ☐ High Cholesterol | OTHER Heart Disease : _____ | |
| ☐ Sleep Apnea | ☐ Asthma | ☐ Urinary Incontinence |
| ☐ Ulcers (peptic ulcers) | ☐ GERD | ☐ Renal Stones |
| ☐ Osteoporosis | ☐ Osteoarthritis | ☐ Rheumatoid Arthritis |
| Diabetes: → | ☐ Type 1 (juvenile) ☐ Type 2 | |
| Thyroid Condition → | ☐ Hyperthyroidism (high) ☐ Hypothyroidism (low) | |
| ☐ Seizures | ☐ Stroke / CVA | ☐ Blood Clots / DVT |
| Headaches: → | ☐Tension ☐Migraine | |
| ☐ Cancer: (provide the type of cancer below): _____ | | |
| ☐ Anxiety | ☐ Depression | |
| ☐ MRSA (a type of staph infection) | ☐ Communicable Disease or Other Reportable Health Condition *Condition:_____ | |

## Surgeries (please include dates & body site/side)

☐ NONE / No Surgeries

| | |
|---|---|
| Surgery: | Date: |
| Surgery: | Date: |
| Surgery: | Date: |
| Surgery: | Date: |
| Surgery: | Date: |

## Family & Social History

**Please list major medical conditions in your mother & father**
(please do not write family names)

Father:_____
☐ Medical History Unknown ☐ Nothing Significant ☐ Age at Death; _____

Mother:_____
☐ Medical History Unknown ☐ Nothing Significant ☐ Age at Death; _____

**Marital Status** (circle):
☐ **M**arried ☐ **S**ingle ☐ **D**ivorced ☐ **S**eparated ☐ **W**idowed

**How much exercise do you do?** _____ times/week ☐ None
Type of Exercise:_____

**Work History** (circle all that apply):
☐ Homemaker ☐ Student ☐ Fired ☐ Medical Leave
☐ Self-Employed ☐ Working ☐ Retired

**What is your Current – or - Prior Occupation? :**
_____

Do you have an **attorney or lawsuit** related to your current problems?
☐ **Y**es / ☐ **N**o

**TOBACCO USE:** ☐ **Never** (Non-Smoker)
☐ **Previous Use** but Quit: Date/Age you Quit: _____
☐Cigarettes ☐ Cigars ☐ Smokeless Tobacco ☐ Other _____
☐**Current** Tobacco Use:
☐ Smokeless Tobacco ☐ Other _____
☐Cigarettes; #_____ per day / #_____ pack week
☐ Cigars; #_____ per day / #_____ per week

**ALCOHOL INTAKE:**
☐ Never ☐ Rarely ☐ Daily alcohol Use
☐ Social Use: Average# of drinks per week? ☐ 1 per week ☐ 1-2 per week
☐ Regular Use: How many times- per week? _____ / per month? _____
TYPE OF ALCOHOL (Check all that apply):
☐ beer ☐ wine: ☐ Other:_____
• **Alcoholism / Alcohol Abuse** →☐ current abuse ☐ prior abuse ☐ AA

**SUBSTANCE ABUSE:** (Check all that apply)
Do you have a history of any of these? ☐ NONE
Street drug use; ☐ current ☐ prior use:
Prescription medicine abuse; ☐ current ☐ prior use -
Drug / Prescription Name:_____

**CHOOSE THE LEVEL OF YOUR ABILITY TO COMPLETE THE FOLLOWING ACTIVITIES:** ( please answer ☒ each activity )

*Bathing: ☐ Independent / ☐ Some Assistance Needed / ☐ Dependent *(unable)*
*Dressing: ☐ Independent / ☐ Some Assistance Needed / ☐ Dependent (*unable)*
*Eating: ☐ Independent / ☐ Some Assistance Needed / ☐ Dependent (*unable)*
*Getting up from bed or a chair: ☐ Independent / ☐ Some Assistance Needed / ☐ Dependent (*unable)*
*Using the Toilet: ☐ I Can control my bladder / ☐ I Cannot control my bladder
* ☐ I Can control my bowels / ☐ I Cannot control my bowels

**PATIENT HISTORY FORM**

Name:_____ Date of Birth:_____ **DATE** Form **Completed:**_____

Are you, ☐ Right Handed or ☐ Left Handed ? ( ☒ please checkmark)

**Chief Complaint** (Brief statement of the problem; reason you are here; what you want from the doctor; etc.):

_____

_____

_____

**History of Present Illness**:

Were you injured at work? ☐ **Y**es ☐ **N**o Were you injured in a Motor Vehicle Accident? ☐ **Y**es ☐ **N**o

Where does it hurt? _____

What does it feel like? _____

How would you describe the pain? _____

What makes it better? _____

What makes it worse? _____

Answer the Following questions by Rating the severity of your pain on a scale of 1-100 –with 100 being the most severe:

On Average, my pain rating is:_____ When the pain is the worst I rate it: _____ When the pain is at its best, I rate it:_____

When did it start? _____

How has it changed since then? _____

Describe any weakness you have. _____

Describe any numbness, tingling or loss of sensation you have. _____

_____

Have you had any change in your ability to control your bowel or bladder? ☐ **Y**es ☐ **N**o

List who you have seen for this problem (doctors, chiropractors, etc.).

_____

_____

_____

Tests Performed: (include Dates & Results if known )

_____

_____

_____

Treatments/Procedures: *(e.g. <u>Past</u> Medications, Injections, PT, Chiropractic, Surgery, etc.)* (include Dates & Results if known )

_____

_____

_____

What activities are you unable to do because of your problem(s)? _____

_____

What activities do you have difficulty with because of your problem(s)?

_____

Anything else you would like us to know?

_____

**Name:** _____ **Physical Medicine & Rehabilitation Clinic of St. Louis**

# Office Policy

Physical Medicine & Rehabilitation Clinic of St. Louis complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

**Appointments:**
PLEASE BRING YOUR INSURANCE CARD AND PICTURE ID WITH YOU TO YOUR APPOINTMENT TO AVOID BILLING ERRORS & TO HELP PROTECT YOUR IDENTITY.

**Cancellations / No Shows:**
CANCELLATIONS WITHOUT 24 HOURS NOTICE GIVEN DURING REGULAR BUSINESS HOURS WILL INCUR A BROKEN APPOINTMENT CHARGE.
We understand emergencies may happen. Please notify the office as soon as possible with the reason for your missed appointment. However, chronic, multiple broken appointments may still incur a charge or may be dismissed from the practice.

**Disability/Medical Forms:**
A SIGNED AUTHORIZATION IS REQUIRED FROM THE PATIENT. Please allow 7-10 days for the completion of these forms and medical record collection. There will be a charge for the completion of medical forms.

**Medical Records:**
YOUR MEDICAL RECORDS ARE HELD IN STRICT CONFIDENCE. Any request for copies or transfer of your medical record must be in writing with authorization for the release from the patient or guardian.
AS A COURTESY & TO PROMOTE COMPREHENSIVE PATIENT CARE, WE WILL PROVIDE RECORDS TO THE PHYSICIAN WHO REQUESTED THE CONSULTATION & TO YOUR PRIMARY CARE PROVIDER
Medical record collection takes time. Please allow 7-10 days for medical record requests. A minimal charge may be required prior to sending the records. We reserve the right to charge for processing and copying information. This fee is waived when releasing information directly to a treating physician for care coordination.
Under workers compensation, we are required to furnish information to the WORKERS COMPENSATION DIVISION, the employer and to any other party involved in the workers' compensation proceeding.

**Electronic Communications:**
E-mail communication may be used to CONTACT PATIENTS ABOUT NEW SERVICES AND DISEASE MANAGEMENT PROGRAMS as they are developed by the practice
PROTECTED HEALTH INFORMATION(PHI): A REQUEST FOR E-MAIL COMMUNICATION MUST BE SIGNED AND ON FILE PRIOR TO ANY E-MAIL COMMUNICATION WHICH CONTAINS PHI
In order to send or process and respond to your e-mail, health care staff, other than your doctor, will read your email. Your email is not a private communication between you and your treatment provider. Your e-mail, at the discretion of your health care provider, may become part of your medical record.
E-mail is a one way communication, Responses or replies may be hours or days apart. Do not use provider-patient e-mail in urgent or emergency situations.
E-mail you send to our practice is NOT secure and is at risk of being sent to an incorrect address or intercepted. Please limit any personal information sent by E-mail.
E-mail is sent at the touch of a button and once sent cannot be cancelled or recalled. Errors in transmission can occur. Unencrypted e-mail provides as much privacy as a postcard on the internet. Messages on your computer, laptop or PDA have privacy risks.

# Financial Policy

Our financial policy has been established to avoid misunderstanding concerning payment for professional services. It is the patient's responsibility to pay any deductible, co-insurance, copay, or any portion of the charges as specified by the plan at the time of visit. Any medical service not covered by an individual's insurance plan is the patient's responsibility and payment in full is due at the time of visit.

**How May I Pay?**
WE ACCEPT CASH, CHECKS, MONEY ORDERS, CREDIT/DEBIT CARDS: DISCOVER, MASTERCARD, VISA
Payment is expected to be paid at each visit. You will be informed what your estimated financial responsibility will be. Since this is an estimate only, we will bill you or credit you for any balance after insurance payment.
Past due account balances greater than 60 days will be turned over to an outside collection agency, unless prior arrangements have been made with the business office.
Once an account has been turned over to a collection agency, you will be responsible for the agency's collection fees (typically an additional 25-35% of your balance due,), and any attorney fees.
THE ADULT ACCOMPANYING A MINOR PATIENT WILL BE RESPONSIBLE FOR FULL PAYMENT OF THE ESTIMATED BALANCE DUE. The practice does not honor divorce specifics (ex: percentage of financial responsibility)

**Payment:**
PAYMENT IS DUE AT THE TIME OF YOUR VISIT
In order to avoid the increasing cost of medical services and to keep the costs to our patients and our practice at a minimum, *WE DO NOT BILL FOR COPAYMENTS, CO-INSURANCE AND DEDUCTIBLES.* The amount you pay at your visit may not be all you owe. Your final responsibility will be determined after your insurance company has received a bill for all services rendered, and has processed and paid your claim.
In the event your insurance company does not make payment within 60 days from the date of service, we will look to you for payment of your charges.
Payment Arrangements: If you are unable to make payment at the time of service, please make prior arrangements with our business office or you may be asked to reschedule your appointment. Payment arrangements will not be offered when Social Security Information is withheld.

**No Insurance/Self Pay:**
WE DESIGNATE ACCOUNTS AS SELF PAY IN THE FOLLOWING CIRMCUMSTANCES. Payment will be due at the time of service
(1) The patient is covered by an insurance plan our provider(s) does not participate in
(2) Patient does not have a current/valid insurance card on file and / or Social Security Information is withheld resulting in insurance benefits and process claims being hampered
(3) Patient does not have health insurance coverage
(4) Patient is covered under a THIRD PARTY LIABILITY PLAN such as accident or motor vehicle insurance or is represented by an attorney

**Insurance:**
FAILURE TO PAY YOUR INSURANCE PREMIUMS MAY RESULT IN A LOSS OF MEDICAL INSURANCE COVERAGE & YOU WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED
YOU ARE FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE COVERED BY INSRUANCE. IN THE EVENT OF DEFAULT THE PATIENT OR PATIENT'S GUARDIAN WILL BE RESPONSIBLE FOR ALL COLLECTION AND ATTORNEY FEES.

- CONTRACTED PROVIDER:

We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. Please verify that we participate as a contracted provider prior to your appointment. In a few cases, we may be able to submit claims to a non-contracted insurance company. Please discuss this with our staff or the business office. .
Failure to follow your insurance guidelines or payment of insurance premiums may result in the visit being denied.

- INSURANCE REFERRALS**:**

▪If your insurance plan requires that you contact them or obtain a referral for your appointment, please do so 1-2 weeks prior to your scheduled appointment. ▪Many insurance companies require at least 7 days to process
▪If we do not have your referral, you may be asked to reschedule, sign a responsibility waiver or provide payment due at the time of your visit.

- SECONDARY INSURANCE:

Having more than one insurance does not necessarily mean that your services are covered 100%. As a courtesy, we will bill your secondary carrier for any balance which remains after your primary insurance payment.
*We do not send secondary insurance claims for office co-payments that are a requirement of your primary insurance carrier.*

- SUBSIDIZED HEALTH INSURANCE / MARKETPLACE INSURANCE PLANS:

Failure to keep current with your monthly premiums may result in a loss of coverage and claim denials.
Following a 90 day period of non-payment of your monthly premiums, your insurance will retro-actively deny claims submitted. The Patient will be liable for all charges incurred following the initial 30 day grace period.

→ PLEASE COMPLETE →

**WORKERS COMPENSATION:**

Before we can schedule an appointment for you. Please have your employer or case manager contact our office. Failure to properly report this injury to your employer may result in your claims being denied. Denied claims are your financial responsibility.
Protected Health Information including treatment and diagnosis will be disclosed to your employer to comply with your employers obligations under state law.

☐ **This is not** a work–related injury

☐ **This is** a work–related injury

☐ **This is, or may be a work-related injury**; ***however, I am selecting a physician for evaluation and/or treatment at my own expense*** *pursuant to Missouri Revised Statutes Chapter 287: Section 287.140* *** A job related injury is not covered by regular health insurance and I will not be reimbursed by my health insurance for this treatment ***

**AUTO ACCIDENT OR LIABILITY INSURANCE:**

☐ **This is not** a third-party motor vehicle or accidental injury claim

☐ **This is** a third-party motor vehicle or accidental injury claim →ACCIDENT DATE: _____ Do You Have An Attorney: ☐YES ☐NO

SIGNATURE of Patient or Guardian:_____ DATE:_____

Name:_____

## Assignment of Insurance Benefits & Release of Information

YOUR SIGNATURE IS REQUIRED FOR INSURANCE BILING

- I hereby give lifetime authorization for payment of insurance benefits to be made directly to PM&R Clinic of St. Louis, and any assisting physicians for services rendered.
- I hereby authorize the release all information necessary to process claims and to secure the payment of benefits
- I hereby authorize the release of all applicable medical information including & without limitation, copies of all records and test results produced to the designated attending, referral, and/or follow up physicians who will be providing subsequent monitoring of care or treatment in connection with care provided by Physical Medicine & Rehabilitation Clinic of St. Louis
- I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act, is correct. (Medicare)
- I request payment of Medicare benefits be made on my behalf to the party who accepts assignment. (Medicare)
- I request that payment of authorized Medigap/secondary insurance benefits be made on my behalf to Physical Medicine & Rehabilitation Clinic of St. Louis. (Medicare)
- I authorize any holder of medical information about me to release to the Health Care Financing Administration & its agents and Medicap Carriers any information needed to determine these benefits or benefits payable to related services (Medicare)
- I further agree that a photocopy of this agreement shall be as valid as the original

The patient or patient's representatives certifies that he/she is the patient, or is duly authorized on behalf of the patient to execute such an agreement

SIGNATURE of Patient or Guardian:_____ Relationship to Patient: ☐ Self ☐ Parent ☐ Legal Guardian

DATE:_____

## E-Mail Communications of Protected Health Information

THIS IS AN ELECTIVE AUTHORIZATION AND NOT REQUIRED FOR TREATMENT

Physical Medicine & Rehabilitation Clinic of St. Louis will use reasonable means to protect the security and confidentiality of electronic information sent and received, including the use of encryption and other security technologies

- E-mail you send to our practice is NOT secure and is at risk of being sent to an incorrect address or intercepted. Please limit any personal information sent by E-mail
- In order to send or process and respond to your e-mail, health care staff, other than your doctor, will read your email. Your email is not a private communication between you and your treatment provider. Your e-mail, at the discretion of your health care provider, may become part of your medical record.
- I understand that electronic communications will be read and responded to as promptly as possible; however, a specific turnaround time is not guaranteed. Thus, I will not use electronic communications for medical emergencies or other time-sensitive matters.
- I understand E-mail is sent at the touch of a button and once sent cannot be cancelled or recalled. Errors in transmission can occur. Unencrypted e-mail provides as much privacy as a postcard on the internet. Messages on my computer, laptop or PDA have privacy risks.
- I understand electronic communication (including secure messaging) and email for patient-provider communications has a number of risks. Including but not limited to: Email can be intercepted, altered, forwarded or used without written authorization or detection / Email can be used to introduce viruses into computer system/ Electronic communications, including email, can be misinterpreted / Email senders can easily misaddress an email / Electronic communications, including email, are easier to falsify than handwritten or signed documents
- I will not use secure messaging or email to transmit information or questions of an urgent nature, and in an emergency I will go to an Emergency Room

☐ I request & authorize the use of e-mail communication of Protected Health Information. Authorization may be revoked at any time in writing.

SIGNATURE:_____ DATE_____

My e-mail address:_____ Relationship to Patient ☐ Self ☐ Parent ☐ Legal Guardian

## Notice of Privacy Practices Acknowledgement

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT*

I have been given the opportunity to read or receive a copy of the Notice of Privacy Practice policy of Physical Medicine & Rehabilitation (PM&R) Clinic of St. Louis, which explains when, where and why my confidential health information may be used or shared.

- Signing does not mean that you have agreed to any special uses or disclosures (sharing) of your health records.
- Refusing to sign the acknowledgement does not prevent a provider from using or disclosing health information as HIPAA permits

X _____ _____

SIGNATURE - Patient or Patient's Representative DATE

X _____ Legal Guardian's Relationship To Patient ☐ Mother ☐Father ☐ Child ☐ Attorney ☐ Other

Printed Name of Patient or Patient's Representative _____

↓ **For Office Use Only** ↓ **Good Faith Efforts:** Good faith efforts were made to obtain the individual or Personal Representative's, if applicable, signature.

❑ Individual or Personal Representative chose not to sign
❑ An emergency situation prevented obtaining acknowledgement
❑ Communications barriers prohibited obtaining the acknowledgement
❑ Other (Please Specify: