To Reschedule or Cancel call 770-834-7436

SOUTHERN THERAPY SERVICES, INC.
PATIENT INFORMATION

| STS USE ONLY | |
|---|---|
| THERAPIST | |
| DIAGNOSIS | |
| ANATOMY | |

DATE: _____ APPOINTMENT TIME: _____

** PLEASE COMPLETE ALL INFORMATION ON THIS FORM AND SIGN BELOW. **

Patient Name: (Last)_____(First)_____(Middle)_____
Mailing Address_____City_____State_____Zip_____
Home Phone ( )_____ Date of Birth:_____/_____/_____Age_____
Cell Phone ( )_____ Email_____
SS# _____/_____/_____ Sex: Male Female Marital Status: S M W D
Patient/Parent Employer_____Occupation_____Phone_____
Employer Address_____City_____State_____Zip_____
Spouse/Parent Name_____ SS#_____/_____/_____
Spouse/Parent Employer_____ Phone_____
In case of Emergency / Not Living With You_____Relation_____Phone_____
Person Responsible For Account_____Relation_____Phone_____
**Have you been seen at Southern Therapy before? YES / NO** When?_____
**Have you received previous therapy any this year? YES / NO** When?_____
Referring Physician Name_____ Date Last Seen?_____

** PLEASE PRESENT COPIES OF CURRENT INSURANCE CARDS TO FRONT DESK **

**CIRCLE INSURANCE TYPE: AUTO MEDICARE WORKER'S COMP. REGULAR INS. CASH**

**ARE YOU ELIGIBLE FOR MEDICARE BENEFITS? Circle YES NO As PRIMARY or As SECONDARY**

INSURANCE NAME: _____ CUSTOMER SERVICE PHONE: _____
INSURED NAMED: _____ MEDICAL PROBLEM: _____
SOCIAL SECURITY # OF INSURED: _____ RELATIONSHIP TO INSURED: _____
INSURED's DOB: _____ EMPLOYER NAME: _____
POLICY # / MEDICARE # _____ GROUP # _____
EMPLOYER / W/C PHONE: _____ EMPLOYER/ W/C CONTACT: _____
DATE OF INJURY: _____ CLAIM W/C #: _____

The statements are true and complete to the best of my knowledge. I understand fully the payment policy and billing procedures of Southern Therapy Services, Inc. I hereby authorize Southern Therapy Services, Inc., to furnish my insurance company (s), attorney, or legal representative all information which said parties may request concerning my present illness or injury. I hereby assign to Southern Therapy Services, Inc., all money to which I am entitled for medical expense relative to the service reported herein. I understand I am financially responsible to Southern Therapy Services, Inc., for charges not covered by my insurance company. I understand my physician has referred me to physical therapy and hereby agree to the treatment and/or test procedures felt necessary by my physician and physical therapist. **I CERTIFY BY MY SIGNATURE THAT I HAVE READ AND AGREE TO THIS POLICY.** I AUTHORIZE INFORMATION TO BE RELEASED FOR UTILIZATION AND QUALITY REVIEW PURPOSES. *A PHOTOSTATIC COPY OF THIS AUTHORIZATION WILL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.*

_____ _____
PATIENT'S SIGNATURE DATE

_____ _____
IF MINOR, PARENT'S SIGNATURE DATE


# FINANCIAL POLICY

We are doing everything possible to keep the cost of medical care down. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our payment policy.

## ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment for all co-pays, percentages, deductibles, and any non-covered procedures is required at the time services are rendered. Southern Therapy Services accepts cash, local personal checks, VISA, and MasterCard. There is a service charge for returned checks.

Please be advised that all returning patients with an outstanding balance of 60 days overdue must make arrangements for payment in full prior to scheduling an appointment.

### INSURANCE:

All co-pays and percentages are due at the time services are rendered.
Your insurance is a contract between you and your carrier. You are ultimately responsible for your charges. Our company accepts almost all types of insurance. Some policies are limited on their coverage; it is your responsibility to check with your insurance on limitations. Limitations may include, but not limited to, non-covered procedures and visit limits. We strive to bring you the highest quality of rehabilitative care at the lowest cost available. However, we are a business and must meet our own needs; therefore, we ask that all patients settle their accounts promptly. For your convenience, we gladly accept cash, check, or credit card. Please let us know if you have any questions regarding your financial responsibility.

If you have a change in your insurance company during the course of your treatment, it is your responsibility to get the updated information to our staff as quickly as possible. Any updates not received that results in the denial of your claims will become your responsibility to pay.

Southern Therapy Services, Inc. does not accept attorney liens or bill third party insurance companies.

### CASH PATIENTS:

In an effort to contain costs to cash only patients, balances cannot exceed $250.00. Any amount in excess of $250.00 will result in payment on the account in full before anymore visits can be scheduled.

As a courtesy; patients with no insurance who pay in full each visit will receive a 20% discount.

### WORKER'S COMPENSATION:

If you claim worker's compensation benefits and are denied such benefits, you will be held responsible for the total amount of charges rendered to you.

MEDICARE:

As a courtesy to our patients, we file all Medicare Part B claims electronically. We also file any supplemental policies to Medicare. If you do not have a supplemental policy, you are responsible for any percentages due according to our contractual Medicare fee schedule.

PATIENT CREDIT:

Southern Therapy Services strives to accurately collect insurance co-pays, deductibles and percentages correctly the first time, however, due to the numerous insurance plans and specifications there may be times where you will incur a patient credit. Upon discharge from STS, our insurance professionals will review each account to identify that all funds have been collected and dispersed appropriately. If a patient credit is due, an acknowledgment will be mailed to the address on the account for you to sign and return. Please allow a maximum of 30 days for refund to be processed.

MISSED APPOINTMENTS/LATE CANCELLATIONS:

Broken appointments represent a cost to us, to you, and to other patients who could have been seen at the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We do not charge for appointments cancelled when 24 hour notice has been given. However, missed scheduled appointments can result in discharge from treatment.

PRIVACY NOTICE INFORMATION

Southern Therapy Services, Inc. will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other healthcare operations. We have prepared a detailed NOTICE OF PRIVACY to help you better understand our policies in regards to your personal health information. By signing below, I hereby acknowledge I have read Southern Therapy Services, Inc.'s Privacy Notice.

I have read and understood the Southern Therapy Services, Inc. Financial Policy. I agree to assign insurance benefits to Southern Therapy Services, Inc. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

_____ _____

Signature of Patient/Responsible Party Date

_____ _____

Southern Therapy Services Representative Date

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*Only to be completed by Southern Therapy Services, Inc.:*

After a good faith attempt to obtain an Acknowledgement of receipt, the patient or representative refused to sign or was unable to sign the Privacy Notice for the following reason(s) _____

_____

_____ _____

Southern Therapy Services, Inc. Representative Date

# Your Appointment Times At Southern Therapy Services, Inc.

Dear Valued Patient:

We appreciate your trust in choosing Southern Therapy Services, Inc. for your rehabilitation needs. Our desire is for your time with us to be "Gold Standard" in every way. We bring state-of-the-art care in a comfortable and education oriented setting and are committed to providing the highest quality rehabilitation services possible.

Healthcare providers are notorious for making patients wait; Southern Therapy Services is the exception. Our goal is to see all patients at their appointed time (no more than 10 minutes beyond this). We ask for your assistance in reaching this goal by observing the following points:

- ***Your scheduled appointment time is reserved for you on your therapist's schedule. If you are running late, please contact our office and establish that we can still keep the appointment or if it is best to reschedule.***

- ***We strive to keep your check-in time at a minimal. On your first visit, please arrive 20 minutes prior to your scheduled visit in order to fill out the required paperwork.***

- ***We realize situations occur that make cancelling an appointment necessary. Please call us at your earliest convenience if you know you must reschedule.***

- ***Our therapists reserve one half hour to one hour per patient. If someone fails to show up to their scheduled appointment without prior notification, our therapists are not able to schedule someone else in your place***

We are honored to serve you and sincerely appreciate each of our patients. If we can assist in any way, do not hesitate to ask.

Southern Therapy Services, Inc.


**CARROLLTON**
812 South Park Street
770-834-7436

**BREMEN**
204 Allen Memorial Drive, STE 301
770-537-6477

**VILLA RICA**
690 Dallas HWY, STE 203
770-459-4555