

Welcome to Lott Physical Therapy.

## ***Focusing on Correction, Education and Prevention***

Welcome to Lott Physical Therapy and Fitness Center!

We realize that you have a choice when selecting your therapy provider. Thank you for choosing Lott Physical Therapy! We will strive to address your personal goals when we develop your program whether those goals involve recovery from an injury, surgical procedure, or general weakness and decline in desired function. We will personalize your care and always provide you feedback on your progress. An individualized treatment plan will be developed during your Initial Evaluation visit to help you achieve your goals and help you reach your highest possible functional level – at home, work and play. This plan will be kept up to date as your symptoms and capabilities change.

Therapy hours are 7:30a – 5:00p Monday through Friday. An answering machine will take your calls when the office is closed. We ask that you are equally committed to your treatment program. If you are ever unable to attend a scheduled appointment, please notify us at least 24 hours in advance. This will enable us to offer that appointment to another client. If you are rehabilitating after an injury or surgery, you will also be asked to perform certain exercises at home in order to expedite your recovery. Please know that these exercises are to help you and to give you strategies to manage your symptoms independently. We will always do our best to help you on your road to recovery; however, remember that you will always be in the driver's seat.

Dress comfortably. Loose fitting shirts, loose fitting pants, long shorts, or shorts beneath a skirt are all appropriate. If the therapist is treating a certain area of the body, wear clothing that will make that area easily accessible without having to expose other areas of the body. A dressing area is available if you wish to change at the facility.

Please sign in for each appointment and alert the receptionist any time your address, phone number, payment or insurance information changes. Take a seat; make yourself comfortable and the office staff will come to get you started. If you wait for more than 5 minutes past your scheduled time and haven't heard from our staff, please let us know – we certainly value your time.

Many of our clients wish to continue their home program in our Fitness Center after discharge from Therapy. This will be discussed, if appropriate, during discharge planning. Dr Lott develops programs that address special areas of concern as well as general fitness to transition many of our clients to a lifelong healthy lifestyle. **Therapy 'Graduates' receive reduced Fitness Center rates.** In addition, if you require a ride to your therapy appointments, we have a program that allows **drivers to utilize the Fitness Center free of charge while they wait.** The **Kids Korner** is also available for clients needing childcare while in therapy: a provider is available M-F 8-10am. Parental or Legal Guardian written consent is required. Please see the receptionist regarding these programs.

After each appointment, please sign out and see the receptionist regarding follow-up appointments or other information. We hope your experience with us is your best ever.

*Dr David Lott  
Physical Therapist  
Selected Best in Texas*

**Lott Fitness Center** open 5a to 11p Every Day – Child Care and Shower Facilities Available

## 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.**

**1) Uses and Disclosures** We will use your protected health information (PHI) for the purposes of treatment, payment and health care operations.

**Treatment** includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians and other physical therapists. For example, we may feel that a stroke patient we are treating would benefit from an evaluation by a speech-language pathologist to address a swallowing difficulty. The health information we share with the speech-language pathologist would be considered a treatment related disclosure.

**Payment** includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was necessary.

**Health Care Operations** includes the utilization of your records to monitor the quality of care being given at our facility or for business planning activities.

### **Other Special Uses**

Our practice may use your PHI to send you an appointment reminder, to inform you of our other health-related products and services, or to request a contribution to our charitable activities.

### **Uses and Disclosures Required by Law**

The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions. We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for workers' compensation or other similar programs that provide benefits for work-related injury or illness.

Your authorization is required before your PHI may be used or disclosed by us for other purposes.

## **2) Your Privacy Rights**

### **Restrictions**

You have the right to request restrictions on how your PHI is used, however, we are not required to agree with your request. If we do agree, we must abide by your request.

### **Confidential Communications**

You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

### **Access to PHI**

You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

### **Amendments**

You have the right to request an amendment be made to your PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create.

### **Accounting of Disclosures**

After April 14, 2003, you have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment, or health care operations or for which we have obtained authorization.

### **Complaints**

If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

### **Our Duty to Protect Your Privacy**

We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

### **Privacy Contact**

If you would like more information about our privacy practices or to file a complaint you may contact: Lisa Lott, Privacy Officer PO Box 1058 Fairfield, TX 75840. Phone 903-389-7433.

### **Effective Date:**

This Notice will take effect on April 14, 2003

# Client Registration

(Please complete all pages. Thank you.)

## CLIENT INFORMATION

CLIENT NAME (Last, First, Middle Initial)		EMAIL	
MAILING ADDRESS			DATE OF BIRTH
PHYSICAL ADDRESS <input type="checkbox"/> Same			
HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	CELL PHONE NUMBER	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> (circle one)

**How did you hear about us?** Doctor \_\_\_\_\_ Radio \_\_\_\_\_ TV \_\_\_\_\_ Billboard \_\_\_\_\_  
Newspaper \_\_\_\_\_ Friend/Relative (who?) \_\_\_\_\_ Other \_\_\_\_\_

## INSURANCE INFORMATION

Primary Insurance Company : _____	Secondary Insurance Company : _____
POLICY HOLDER: <input type="checkbox"/> Myself <input type="checkbox"/> Other: _____	POLICY HOLDER: <input type="checkbox"/> Myself <input type="checkbox"/> Other: _____
<b>EMPLOYER PAID GROUP INSURANCE</b>	
Is the policy holder currently employed by the employer providing insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	
On medical leave? <input type="checkbox"/> Yes <input type="checkbox"/> No COBRA? <input type="checkbox"/> Yes <input type="checkbox"/> No Retired? <input type="checkbox"/> Yes <input type="checkbox"/> No	
IF ON MEDICAL LEAVE OR ON COBRA, WHAT IS THE END DATE? / /	
HR DEPARTMENT CONTACT: _____	TELEPHONE NUMBER: _____

## POLICY HOLDER'S INFORMATION (IF NOT THE CLIENT) Primary or Secondary

NAME <input type="checkbox"/> Same	RELATIONSHIP TO CLIENT
ADDRESS (if different from above)	DATE OF BIRTH
CITY STATE ZIP	HOME TELEPHONE (if different from above)

## FINANCIALLY RESPONSIBLE PARTY'S INFORMATION

If other than Client, Responsible Party to sign Financial Agreement

<input type="checkbox"/> <b>Client</b> See SSN Box ONLY	NAME	RELATIONSHIP TO CLIENT	SOCIAL SECURITY NUMBER OR TAX ID (Required unless services paid in full at time of service)
ADDRESS <input type="checkbox"/> Same	DATE OF BIRTH <input type="checkbox"/> Same		
CITY STATE ZIP	HOME TELEPHONE <input type="checkbox"/> Same		

## EMERGENCY CONTACT

NAME (Last, First, Middle Initial)	RELATIONSHIP TO CLIENT
ADDRESS CITY STATE ZIP	TELEPHONE #

## Billing Information

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

**Is the reason you are here related to an injury**  Yes  No **or illness**  Yes  No

**IF YES** date first treated for this condition \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Have you been treated for the same/similar symptoms previously?  Yes  No  
**IF YES**, first date treated: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

### If an injury:

Is there a third party involved (auto insurance, business, etc)?  Yes  No  
Explain: \_\_\_\_\_

Was this injury/illness related to an accident in which you intend to file a liability suit or litigation is pending?  Yes  No

**IF YES** please provide: Attorney's name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_

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### MEDICARE AND MEDICAID clients

Have you received help in the home from an agency (bathing, aide, therapy, nurse) in the past three months?  No  **Yes** Dates: \_\_\_\_\_

**If yes**, what home health agency provided the services?

Agency name \_\_\_\_\_ Tel# \_\_\_\_\_

Receptionist:  MCare Call completed and HH info verified by (staff name): \_\_\_\_\_

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### MEDICAID clients

Reason for visit: \_\_\_\_\_

Have you had therapy for this problem before?  **Yes**  No

**If yes**, when? (dates) \_\_\_\_\_ Where? \_\_\_\_\_

Receptionist: 180 days ends: \_\_\_\_\_ / \_\_\_\_\_ Above Info verified by: (staff name) \_\_\_\_\_

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### PRIVATE INSURANCE clients

Does the insurance consider this diagnosis a pre-existing condition?  Yes  No

# Client History

The following questions are needed by your therapist to develop the best plan of care for you. Answers to these questions will be held in strict confidence.

1. Why are you seeking physical therapy services? \_\_\_\_\_  
When did the pain or problem begin? \_\_\_\_\_
2. Have you seen someone (physician/chiropractor) for this problem recently?  Yes  No  
If yes, name of provider and date seen? \_\_\_\_\_
3. Is this visit because of an injury?  Yes  No
  - a. **If yes**, have you ever been injured or suffered previous pains/problems in the area(s) before this injury?  Yes  No If yes, when? \_\_\_\_\_
  - b. Have you had a recent X-ray, CT, or MRI of injured area?  Yes  No  
When \_\_\_\_\_ Where \_\_\_\_\_
  - c. Did you recover from this injury?  Yes  No
4. **Female client:** Are you pregnant?  Yes  No  Maybe

5. From the list below, please check those activities that you are either unable to perform in a normal fashion or have difficulty performing because of your pain/problem.

	<u>Difficult</u>	<u>Unable</u>		<u>Difficult</u>	<u>Unable</u>
Sit	[ ]	[ ]	Housework	[ ]	[ ]
Stand	[ ]	[ ]	Yard work	[ ]	[ ]
Walk	[ ]	[ ]	Twist	[ ]	[ ]
Push	[ ]	[ ]	Bend	[ ]	[ ]
Pull	[ ]	[ ]	Squat	[ ]	[ ]
Lift	[ ]	[ ]	Drive	[ ]	[ ]
Stretch	[ ]	[ ]	Ride in car	[ ]	[ ]
Climb	[ ]	[ ]			

6. Please list below any medication/supplement/vitamins taken on a regular basis.

\_\_\_\_\_

\_\_\_\_\_

7. Please list prior surgeries: \_\_\_\_\_

\_\_\_\_\_

8. Do you have or have you had any of the following?

	Now	Past		Now	Past
Dizziness			Chest Pain		
Stroke			Irregular heartbeat		
Arthritis			High blood pressure		
Asthma			Cancer		
Diabetes			Shortness of breath		
Pacemaker			Heart disease		
TB			HIV		
HEP C			HEP B		

# Informed Consent for Treatment

**COMPLETE IF OVER THE AGE OF 18 YEARS OF AGE:**

The undersigned, being over the age of eighteen (18) years and being under no disability or prohibition that would in any way prevent or affect the Consent and Release, does hereby represent that, I \_\_\_\_\_ **(CLIENT)**, consent to rehabilitation treatment as prescribed by my provider.

**COMPLETE IF THE CLIENT IS A MINOR OR WHEN THE ADULT CLIENT IS NOT COMPETENT:**

In the treatment of \_\_\_\_\_ **(MINOR/ADULT CLIENT)**, I \_\_\_\_\_, client representative, of said minor/adult consent to rehabilitation treatment as prescribed by minor's/adult's provider. My relationship to the client is (i.e. parent, son, daughter, etc) \_\_\_\_\_.

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I certify that the information I have provided is complete and true to the best of my knowledge.

I give my authorization for treatment records to be released to the responsible payor for reimbursement consideration, or medical facility necessary for treatment or further care. Additionally, I request that any medical records requested by this facility, necessary for treatment or further care, be forwarded to this facility upon its request.

I understand that I am financially responsible for all charges whether or not paid for by said insurance (i.e. deductible amounts, co-insurance, co-pay, or any other balance not paid by my insurance). If this account is assigned to an attorney for collection and/or suit, the facility shall be entitled to reasonable attorney's fees and costs of collection.

I request that payment of authorized benefits be made on my behalf to this facility. I assign the benefits payable to which I am entitled to this facility for services rendered. This assignment will remain in effect until revoked by me in writing. A photocopy and/or facsimile of this assignment is to be considered as valid as an original.

I have received a copy of the Notice of Privacy Practices for Lott Physical Therapy a d.b.a. of Rural Rehab Providers, LLC. Rural Rehab Providers, LLC reserves the right to modify the privacy practices outlined in the notice.

I have read the foregoing and I understand it. Any questions that have arisen or occurred to me have been answered to my satisfaction.

\_\_\_\_\_  
**Client or Client Representative Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

# Financial Policy

This is an agreement between **Rural Rehab Providers, LLC dba Lott Physical Therapy**, as creditor and the Client/Debtor named on this form.

In this agreement the words “you”, “your”, and “yours” mean the Client/Debtor. The word “account” means the account that has been established in your name to which charges are made and payments credited. The words “we”, “us”, and “ours” refer to Rural Rehab Providers, LLC dba Lott Physical Therapy.

By executing this agreement, you are agreeing to pay for all services that are received.

**Monthly Statement:** If you have a balance on your account, we will send you a monthly statement. No more than 2 statements will be sent if payment is not received.

**Payments:** Unless we approve other arrangements, the balance of your statement is due and payable when the statement is issued, and is past due if not paid within 21 days.

**Charges to Account:** We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

**Required Payments:** Any co-payments required by an insurance company must be paid at the time of service. This is required by your insurance. Any deductibles are due at the time of service. Coinsurance will be handled on a case by case basis.

**Payment if you have no insurance:** You choose to pay cash, check or credit card (MasterCard or Visa) on the day that treatment is rendered. We can also set up automatic credit card debit or a bank draft from a checking or savings account.

Payment plans may be available on a case-by-case basis. Please let us know today if you will be needing arrangements for a payment plan.

**Payment options if you have insurance:**

1. You will be asked to pay deductible, co-pays and possibly coinsurance (i.e. % insurance does not cover) at the time of service. This is payable by cash, check or credit card. (MasterCard or Visa)
2. Your insurance will be called prior to treatment and we will attempt to contact you to discuss financial arrangements if

your insurance policy benefits state that you have a deductible, co-pay, or coinsurance amount in which you will be responsible for.

3. Any deductibles not yet met will be due and payable by you on the day of service.
4. Any co-pay will be due and payable by you on the day of service.

**Insurance:** Insurance is a contract between you and your insurance company. An insurance card must be made available to us before you are seen as a client. Even though we may estimate what your insurance will pay, it is the Insurance Company that makes the final determination of your eligibility. You are responsible for any amount not paid by the insurance less the amount written off due to a contract we may have with your insurance company. If your insurance requires a referral or authorization, you are responsible for obtaining it. Often we can do this for you. Failure to obtain the referral or authorization may result in reduced payment from the insurance company.

**Divorce:** In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment (signing consent) for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment cost, it is the authorizing parent's responsibility to collect from the other parent.

**Past due accounts:** If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your debt to a collection agency, you agree to pay additional collection costs incurred from address searches, credit reports or attorney fees which can possibly equal 50% of the balance due. We may also take the claim to Small Claims Court. You agree to pay any court fees incurred in trying to collect the past due balance. We have the option to report your account status to any credit reporting agency such as credit bureaus.

**Returned checks:** There is \$25.00 fee for any checks returned by the bank. We prefer payment in cash on accounts with history of a returned check.

**Missed appointments:** We strive to respect the rights of all clients to access therapy services by maintaining continuity of scheduling. The second time a client does not show up on time for an appointment, or cancels with less than 12 hours notice, we will need to schedule appointments one

at a time (rather than a week at a time). Extenuating circumstances will be considered. Clients with three missed appointments may need to be discharged from therapy and a new referral obtained from the provider.

**Waiver of confidentiality:** You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if you're past due status is reported to a credit reporting agency, the fact that you receive treatment at our office may become a matter of public record.

**Workers' Compensation:** We require authorization by your workers' compensation carrier (not employer) prior to your initial visit. If your claim is denied, you will be responsible for payment in full. If your case is in dispute, we will require payment at the time of service until we receive information stating your employer's carrier will pay for services. Please remember that in order to receive your Work Comp benefits, you must keep your appointments.

**Medicare:** Medicare requires the client see a provider at least every 60 and 30 days thereafter while receiving physical therapy. In order for Medicare to continue to pay for your therapy, we must include verification of a provider visit in our record.

**Personal Injury:** If you are being treated as part of a personal injury lawsuit or claim, we require payments to be made at the time of service. In addition to this, we require that you allow us to bill your health insurance. Payment of the bill remains your responsibility. We cannot bill your attorney for charges incurred due to a personal injury case. You also acknowledge that your signature also serves as an Assignment of Health Care Benefits and you authorize your attorney or liability carrier to pay those lien amounts to us out of any settlement proceeds without further authorization from you.

**Co-signature:** If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent changes.

**Effective date:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. This agreement applies to previous, current or future transactions.

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Client's name

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Date

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**Printed Name of Financially Responsible Party**

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**Responsible Party's Signature**

**If you would like a copy of this agreement please ask for one and it will be provided to you.**