ERW™ PHYSICAL THERAPY

OUR MUTUAL AGREEMENTS

Welcome to ERW™ Physical Therapy. Our goal is to make your visit with us a pleasant and rewarding experience. The success of your rehabilitation efforts depends on your personal commitment and participation. Based on your available insurance or the circumstances surrounding the injury that has caused you to seek this treatment, the commitment required of you may be one of both time and finances (Please read carefully our Financial Policy below).
We realize that your time and finances are both important however in return for your commitment, we promise to dedicate our time, professional skills, effort, and compassion. We are committed to providing you with excellent professional care and customer service in a caring and professional environment. Communication is at the heart of any successful rehabilitation effort so please be sure to share with us any information that you think may be of assistance with our efforts.

Our commitments to you:

- Excellent customer service
- Professionalism
- Flexible scheduling
- Respect for your time-seen within 15 minutes of scheduled appointment time

Our requirements of you:

- Respect for our time-prior day cancellation notice
- Timely arrival for your appointment
- Participation in prescribed home program
- Honest and open communication

We realize that unforeseen events may occur which require you to cancel your appointment on the same day it is scheduled, however we expect that this will be rare.

1) A same day cancellation is defined as contacting our office on the day of your appointment in order to cancel or reschedule.
2) A No-Show is defined as failure to show up for your appointment without cancelling prior to your appointment time. Contacting us after your appointment time in order to cancel or reschedule the appointment will be considered a No-Show.

In order that we might provide the best possible care to all of our patients, A No-Show or multiple same day cancellations will result in one or both of the following:

- Discharge from care with a notification letter to your referring physician
- A fee of $50 being assessed to your account

If we fail in any way to meet your expectations, please notify the clinic manager so that we may correct and resolve your concerns.

I have read and understand the above requirements _____

Signature of Patient/Responsible Party

Patient Information Sheet

Today's Date: _____

Patient Name: _____
Last First M.I.

Date of Birth: _____ Gender: ☐ M ☐ F Email Address: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home PH: ( ) _____ Cell PH: ( ) _____ Work PH: ( ) _____

Emergency Contact Person: _____ Phone: ( ) _____

My condition is related to:

☐ Work ☐ Auto Accident (state_____) Other: _____

Onset/Date of Injury: _____ Primary Care Physician: _____

Employer Name & Address: _____

_____

Within the last 12 months have you received care in your home for any condition, to include, Nursing, Occupational Therapy or Physical Therapy? ☐ Yes ☐ No

If yes, please list what agency you used and when your last month of service was: _____

_____

How did you hear about us? _____

Why did you choose this clinic? _____

Med pay Insurance Information

This is coverage that is offered with your personal auto insurance

Do you have med pay coverage? ☐ Yes ☐ No

If YES, please specify the coverage amount: _____

If NO, please skip section and complete Third Party Insurance Information below

Name of Insurance: _____ Insurance PH: ( ) _____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____

Policy / Claim Number: _____

Third Party Insurance Information

Name of Insurance: _____ Insurance PH: ( ) _____

Insurance Address: _____

City: _____ State: _____ Zip Code: _____

Policy / Claim Number: _____

Adjuster Name: _____ Phone: ( ) _____

Authorization to Release Medical Records

(List any office that may request your therapy records. Ex. Attorney, non-referring physician)

I, _____ authorize release of my ERS medical records by written or verbal communication to the following, if requested:

_____
(Name of authorized person / office)

_____
(Name of authorized person / office

Authorization for Release of Appointment/Billing Information Records

(List any person that may call, on your behalf, to make or change appointments or ask billing questions. Ex. Spouse, child, caregiver)

I, _____ authorize release of my appointment and/or billing information to the following person(s) listed below:

_____
(Name of authorized person or persons)

_____
(Name of authorized person or persons)

_____ _____
(Signature of patient) Date

PROTECTED HEALTH INFORMATION (PHI) ACKNOWLEDGMENT
STATE OF GEORGIA AUTHORIZATION

Protected Health Information Acknowledgment Pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

By my signature below, I hereby acknowledge receipt of the Evans Rehabilitation Services' Notice of Privacy Practices related to a list of the specific practices of use and disclosure of Protected Health Information (PHI) by Evans Rehabilitation Services.

Authorization to Receive Therapy

The undersigned grants authority to Evans Rehabilitation Services, LLC and its staff to perform procedures and treatments deemed necessary for this patient and generally are used in the care of patients in this and similar physical therapy facilities. Additionally, the undersigned grants permission for the ERS staff to provide emergency treatment if it is needed, or to transfer this patient to a local hospital for emergency treatment deemed necessary by the hospital medical staff.

Authorization to Release Information

I hereby authorize the release by Evans Rehabilitation Services ("ERS") of any and all of my medical information or medical records necessary to process any and all insurance claims on my behalf. I further authorize any and all other medical providers and/or holders of medical information about me to release any and all of such records and information to ERS as requested by ERS to determine the eligibility for and process the claims of ERS related to the provision of rehabilitation services to me.

Payment Authorization

The undersigned hereby assigns unto Evans Rehabilitation Services all rights to receive payment from my insurance company for the provision by ERS of Physical Rehabilitation Services and I direct my insurer to pay any and all amounts due for the provision of such services directly to Evans Rehabilitation Services.

I acknowledge having read and hereby agree to each of the above acknowledgment/authorizations.

_____
Signature of Patient/Responsible Party

_____
Please print patient's name

Date: _____

Financial Policy

While our main concern is that you receive the proper care and optimal treatment needed to restore your health, financial realities and insurance regulations and contracts require that we fully understand the circumstances that gave rise to your injury so that we may determine what individual or insurer may be responsible for the payment of the charges related to your care.

ULTIMATLEY EACH INDVIDUAL IS RESPONSIBLE FOR THE PAYMENT OF ANY CHARGES RELATED TO THEIR OWN CARE AND TREATMENT. AS A COURTESY WE WILL ASSIST YOU, WHERE APPROPRIATE, BY FILING CLIAMS FOR THE PAYMENT OF YOUR CARE WITH HEALTH INSURERS OR OTHER INDIVIDUALS OR ENTITIES. IN THE EVENT THAT THE CHARGES FOR YOUR CARE ARE NOT COVERED OR PAID FOR BY OTHERS, YOU AGREE TO PAY US IN ACCORDANCE WITH THE FINANCIAL POLICIES SET OUT HEREIN.

Health Insurance: We will file your insurance as a courtesy to you. However, you must understand the following:

1. Should your insurance require any pre-certification or authorization, please make sure that you or your referring physician have obtained such pre-clearance prior to beginning any treatment. THIS IS YOUR RESPONSIBILITY. If you are unsure whether any such preauthorization is required for your care, and whether is have been obtained, please make this inquiry as any charges incurred without the proper authorization will be the responsibility of the patient.

2. **Your insurance policy is a contract between you and your insurance company, not Evans Rehabilitation Services.** All charges are ultimately the patient's responsibility. Not all services are a covered benefit, so please know and understand your policy. If your insurer does not pay ERS, our charges will be your responsibility.

3. Health Insurance co-payments are required to be paid at the time of service.

THIRD-PARTY LIABILITY

If your condition is due to a motor vehicle accident or otherwise results from circumstances that give rise to a legal claim against another individual or entity, please see our Coordination of Benefits notice and related financial policy that follows.
Nearly all health insurance policies contain "Coordination of Benefit" ("COB") language and most governmental payers (Medicare, Medicaid and Tri-Care) have similar program requirements and guidelines. These COB provisions require that health care providers identify instances when the injury they are treating was sustained in such a way that the patient has a claim against some individual or entity ("Third Party") and the claim against such Third Party includes a claim for reimbursement of the cost of the medical treatment being provided (a "Third-Party Claim"). The following language is a sample of actual COB language that exists in contracts that ERS has with insurers:

"Provider…will cooperate with (Insurer) to identify any and all parties, other than (the Insurer), that may be responsible for payment of, or reimbursement for, Covered Services, and for the purpose of coordinating benefits with other payers. When a party other than payer is identified as having primary responsibility for payment of or reimbursement for Covered Services under the coordination of benefits of a Member's Health Benefits Plan, Provider…will bill and make all reasonable efforts to collect from such party for the value of Covered Services."

In addition to these COB plan provisions which require that we attempt to collect our charges from any at fault third parties, most health insurance plans also contain provisions which allow an insurer who has paid us benefits for your care and treatment but then subsequently discovers that the claim was the responsibility of some at fault third party, to

request that we refund to them the amount of any such benefits and by contract we are then required to make such refunds. If this occurs, all contractual adjustments would be reversed, and the patient would then be billed the full amount of the charges for such refunded visits. Accordingly, it is imperative that we have accurate and complete information throughout the course of your care and treatment so that we might comply with these legal requirements and avoid having to bill you for this care. **When the injury that we are treating has given rise to a Third-Party Claim, we are generally legally prohibited from billing your insurer without first attempting to collect the cost of your care from the At Fault Third Party.** If these circumstances apply to your claim, please fully complete the following Third Party Liability claims material and notify us if and when you discover that your claim circumstances have changed or you discover other information related to the claim or the identity of the at-fault party so that we might update our records.

To the best of your knowledge, did the injury for which we are treating you give rise to a claim against another individual or their insurance company?

Yes: ☐ **No:** ☐

If so, are you presently represented by an attorney? (Please provide your attorneys name and contact information as well as, a brief description of the incident, accident or occurrence, and the name of the at fault party and/or their insurance company):

_____

_____

_____

THIRD PARTY LIABILITY PAYMENT POLICIES AND PAYMENT AGREEMENT

The following language explains the payment policy that we have designed specifically for our patients whose injury gives rise to a Third Party Liability (TPL) claim against another individual or entity. We will file our claim with your insurance company for any Medical Payment (Med-Pay) benefits that may apply to this claim and which may be available pursuant to your insurance policies. In the event such benefits are not available or do not satisfy the charges for your care and treatment, we agree to treat you, without payment, while your care is ongoing and your TPL claim is being legally pursued however this is conditioned on the following:

- You agree to provide us with a credit card to secure the payment of your obligations as herein provided;
- You agree to instruct your attorney to withhold from any settlement of your claim and to remit directly to us, funds sufficient to satisfy the outstanding balance on your account;
- Any charges not paid within thirty (30) days of billing will accrue finance charges at the rate of twelve (12%) percent per annum;
- We will bill you monthly for the charges of your care and treatment and you agree to pay us a minimum of one hundred dollars ($100.00) per month;
- In the event your claim has not been settled or your account at ERS is not paid in full at the conclusion of six months following the completion of your treatment, you agree to pay in full at that time all remaining charges then due on your account;
- In the event that you fail to pay when due any monthly payment, you agree that we may charge your credit card for the monthly payment then due on your account
- In the event your account is referred to a collection agency or attorney for collection, you agree to pay all cost associated with the collection of your account.
- ALTERNATIVELY, you may simply pay in full for your treatment at the time rendered.

In the event the injury for which we are treating you gives rise to a claim against another individual or entity who is, or is contended to be legally responsible or liable for such injury or otherwise responsible for the payment of, or reimbursement for the charges arising from your rehabilitation treatment at ERS, we will make all reasonable attempts to recover the charges for your treatment directly from any such at fault third party. Incident thereto, you agree to provide us with any and all information which may be convenient, necessary or helpful to making such recovery, including, but not limited to: (a) the names and contact information of any and all such third parties and/or their insurers, contended to be at fault and responsible for the payment of such care; (b) the details of the circumstances surrounding the incident which caused the injury for which we are treating you; and (c) the name and contact information of any attorney(s) representing you with regard to any such third party claim and the name and contact information of any attorney(s) representing any such third party contended to be responsible for your accidental injury. The undersigned further agrees to keep Evans Rehabilitation Services (ERS) apprised as the undersigned learns of any changes, corrections or additional developments as regards the information initially provided.

While the undersigned is ultimately responsible for the payment of any and all of the charges of ERS related to the treatment of the undersigned, ERS agrees to work with and temporarily defer the payment of the charges of the account of the undersigned as herein specifically provided. In consideration thereof, the undersigned agrees to make minimum payments as herein provided while ERS attempts to make collection from any and/or all third party(ies) contended to be legally responsible or liable for such injury or otherwise responsible for the payment of, or reimbursement for, the charges arising out of your rehabilitation treatment. The undersigned will make payment to ERS of a minimum amount of one hundred dollars ($100.00) per month beginning with the earlier of:

(1) the first day of the first month (1st) following the discharge by ERS of the undersigned; or
(2) the first day of the seventh month (7th) month following the initial treatment of the undersigned by ERS.

The undersigned agrees to pay ERS a minimum monthly payment of one hundred dollars ($100.00) per month with such payment to be due and payable on or before the tenth day (10th) of the first month as provided above and thereafter on or before the tenth (10th) day of each and every month thereafter until the account of the undersigned is paid in full. In order to facilitate such minimum monthly payment, the undersigned agrees to provide ERS with a credit card authorization allowing ERS to make monthly draws upon such card or account in the amount of $100.00 per month unless ERS receives some other form of payment by the tenth (10th) day of each month. In addition to such minimum monthly payments, the entire outstanding and unpaid balance of the account of the undersigned shall be due and payable upon the earlier of: (a) ten days following the date upon which the undersigned settles any claim against any at fault third party as hereinabove described; or (b) six months following the completion of the rehabilitation treatment provided by ERS.

Beginning with the thirty-first day (31st) following the initial billing by ERS of the account of the undersigned, the undersigned agrees to pay ERS a finance charge equivalent to twelve percent (12%) per annum with such finance charge being computed on the entire outstanding balance of the account of the undersigned. Interest will be computed on the basis of a three hundred sixty (360) day calendar year. In the event the account of the undersigned is not paid as and when due, including any minimum monthly payment, or the full account balance payment, all as herein provided, ERS shall be entitled to immediately collect the entire unpaid balance of the account of the undersigned without further notice and in addition to the finance charges described above, the undersigned agrees to pay all costs of collection.

THE UNDERSIGNED HAS READ AND AGREED TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND AGREES TO MAKE PAYMENT OF THEIR ACCOUNT AS HEREIN PROVIDED.
THIS THE _____ DAY OF _____, 20___.

_____ _____
PATIENT SIGNATURE PRINTED NAME

PHYSICAL THERAPY

DIRECTION TO MY ATTORNEY:

Please withhold from any settlement of my Third Party Liability claim and remit directly to Evans Rehabilitation Services, funds sufficient to pay any and all charges, and all interest due thereon, which charges arise from my care and treatment at Evans Rehabilitation Services following _____, the date of my injury which necessitated the care, treatment and rehabilitation services being provided by Evans Rehabilitation Services. This the _____ day of _____, 20____.

_____ _____

PATIENT SIGNATURE PRINTED NAME

AUTHORIZATION TO: Evans Rehabilitation Services, LLC: I have given my authority to the below named credit card company to honor preauthorized EFT/Charge drawn by Evans Rehabilitation Services on my account for the membership payments as indicated below. It is understood that the transmission of a preauthorized draft to the bank as payment becomes due shall constitute valid notice of such payment due on the above named activity. When the bank honors the draft by charging my account, such draft shall constitute my receipt for the payment. Should any preauthorized draft not be honored by said bank when received by them, then it is understood that the payment will be collected electronically as well as a $50.00 NSF service fee.

- We will bill you monthly for the charges of your care and treatment and you agree to pay us a minimum of one hundred dollars ($100.00) per month until your balance is settled
- In the event that you fail to pay when due any monthly payment, you agree that we may charge your credit card for the monthly payment then due on your account
- Any charges not paid within thirty (30) days of billing will accrue finance charges at the rate of twelve (12%) percent per annum

I choose to utilize the Credit Card Payment option for my payments (automatic direct charge to credit card)

Credit Card Type: ☐ Visa ☐ MasterCard ☐ Discover

Amount: $100.00 Frequency: Monthly

Credit Card Number_____

Expiration Date_____ Security Code_____

Card Holder Name: _____

Card Holder Signature: _____ Date: _____

PHYSICAL THERAPY

Medication List

Medication	Dosage	Medication	Dosage

Non-Prescription Meds:

Medication	Dosage