MID STATE THERAPY SERVICES
New Patient Packet

New Patient Registration must be completed prior to your appointment.

To complete the New Patient Registration Packet, follow these instructions:

1. **Please read and complete the enclosed forms prior to your scheduled appointment.**
2. **Be sure to sign, date, or provide your initials where necessary to ensure completeness.**
3. **Please be sure to bring all original copies of the forms to your appointment.**
   In addition, you will need to provide a copy of your insurance card and driver's license. If filing student insurance, please bring a copy of the school injury form.

You can either bring the completed forms with you to your appointment or:

- **Fax the forms to (318) 442-0562**
- **Scan and email the forms to: MSTSinfo@midstateortho.com .**

REMINDER:

- ***On your first visit our staff will verify your information. You will need to provide a copy of your insurance cars and driver's license. Be sure to include secondary insurance if you plan on filing it.***

Prior to your visit, please feel check out our website at www.midstatetherapyservices.com to learn more about our therapists, services, etc.

Thank you for choosing MID STATE THERAPY SERVICES!

Thank You

MID STATE THERAPY SERVICES

Patient Registration Form

PATIENT INFORMATION

First Name _____ MI _____ Last Name _____

Date of Birth _____ SS # _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Gender _____ Marital Status _____ Email _____

EMERGENCY CONTACT INFORMATION

First Name _____ Last Name _____

Phone _____ Relationship _____

REASON FOR VISIT (If MVA or Workers Compensation, please complete Accident Form also.)

Problem Description _____ Date of Injury _____

PRIMARY INSURANCE INFORMATION

Insurance Name _____ ID # _____ Group # _____

Subscriber Name _____ Subscriber DOB _____ Relationship _____

SECONDARY INSURANCE INFORMATION

Insurance Name _____ ID # _____ Group # _____

Subscriber Name _____ Subscriber DOB _____ Relationship _____

TERTIARY INSURANCE INFORMATION

Insurance Name _____ ID # _____ Group # _____

Subscriber Name _____ Subscriber DOB _____ Relationship _____

GUARANTOR INFORMATION (If patient is under 18 years of age.)

Guarantor Name _____ Guarantor DOB _____ Relationship _____

Mailing Address _____

Employer _____

Guarantor Phone

I authorize release of any information requested by my insurance plan for claim processing and payment.
I understand that copays, coinsurance, or deductible amounts are collected at time of service.
I understand I am financially responsible for any balance due after claims have been processed.
I agree to comply with all the terms and conditions outlined on the Registration Form.

By signing below, I acknowledge I have received the Notice of Privacy Practices.

Signature _____ Date _____

MID STATE THERAPY SERVICES

Accident Information Form

Was your injury caused by a work-related accident or an auto accident? ( ) NO ( ) YES

PLEASE READ THIS STATEMENT AND ANSWER THE FOLLOWING QUESTIONS:
The following information MUST be obtained in order for your claim to be paid by your insurance company. As a courtesy service, we file these for you. If we do not receive payment from your insurance company within 90 days of date of service, you will be responsible for the entire amount of the visit. The following questions reflect information your insurance company will require.

INSURANCE QUESTIONS REGARDING YOUR ACCIDENT
(Only Complete this Section if you answered "YES" above)

WHAT WAS THE DATE OF YOUR INJURY?	WHERE DID YOUR INJURY OCCUR?	IN WHAT STATE DID IT OCCUR?
HOW DID YOUR INJURY OCCUR?		
WAS THE INJURY WORK-RELATED? ( ) NO ( ) YES	WHAT WAS YOUR JOB TITLE?	ARE YOU STILL EMPLOYED BY THIS EMPLOYER? ( ) NO ( ) YES
WHAT WAS YOUR OCCUPATION AT THE TIME OF YOUR INJURY?		
IF YOU THERAPY IS BEING HANDLED BY WORKERS COMPENSATION, PLEASE PROVIDE THE FOLLOWING: ADJUSTOR'S NAME:		PHONE:
WAS THIS INJURY THE RESULT OF AN AUTOMOBILE ACCIDENT? ( ) NO ( ) YES	WAS A THIRD-PARTY RESPONSIBLE? IF YES, GIVE THE NAME AND ADDRESS OF THE THIRD-PARTY.	
NAME DOCTORS YOU HAVE SEEN FOR THIS INJURY AND ANY SURGERIES:		

MID STATE THERAPY SERVICES
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996, also known as HIPAA, is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This ACT gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practices, such as conducting quality assessments and improvement activities, auditing functions, cost management analyses, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.
You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer of our practice:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communications of protected health information from us by alterative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of April 14, 2003, and we are required by the terms of our *Notice of Privacy Practices* and to make the new notice provisions effective for all protected information that we maintain. We will post a revision made to this notice and you may request a copy of our new policy at any time.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:
MID STATE THERAPY SERVICES – Privacy Officer
429 Rocky Bayou Drive
Pineville, LA 71360
(318) 545-4120

For more info about HIPAA or to file a complaint:
U.S Dept. of Health & Human Services, Office of Civil Rights
200 Independence Ave., S.W.
Washington, D.C. 20201
202-619-0257 or toll free877-696-6775

Keep this for your records

MID STATE THERAPY SERVICES

PATIENT NAME _____ **DATE OF BIRTH:** _____

Notice of Privacy Practices

_____ ***(Patient Initials)*** I understand that under the Health Insurance Portability & Accountability Act of 1996; also known as HIPAA, I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge receipt of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy.

Release of Information Agreement

_____ ***(Patient Initials)*** I am authorizing that the following individuals (if any) may have access to information about my medical condition at this clinic.

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

[ ] NO INDIVIDUAL IS AUTHORIZED TO ACCESS MY MEDICAL INFORMATION.

Consent for Text / Email Communication

_____ ***(Patient Initials)*** I consent to receive emails for appointment reminders, request for information, general health information, home exercise programs or other information feedback.

I authorize Mid State Therapy use of the following email address: _____

_____ _____ _____

Patient Signature (or responsible person) *Relationship to Patient* *Date*

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement and Release of Information Agreement, but was unable to do so as documented below:

Date: _____ **Initials:** _____ **Reason:** _____