Thank you for choosing The Therapy Network for your physical therapy care.

Please fill out all paperwork with black ink as these forms will be scanned to become part of your medical record.

You may update this information at any time

For your first appointment:

Plan to arrive 30-45 minutes prior to your scheduled appointment. This will allow time to properly register you in our system and time to answer any questions you may have about the services

Fill out these forms BEFORE you arrive for your appointment AND BRING THEM WITH YOU.

Bring your current insurance card and photo ID

Feel free to call if you have any questions!

Thank you!

Patient Information: **Acct#:________________**

Last Name: ________________________ First Name:_________________________ Middle Initial:_____________

Date of Birth: _______/_______/____________ Social Security Number: _____________-________-___________

E-Mail Address: (highly encouraged) ____

Emergency Contact Name: ______________________________ Emergency Contact Phone: (____) _____-_________

Was this injury a result of a Motor Vehicle Accident(Y/N): __________ If Yes, Date of Accident: _______________

Name of Attorney: _______________________________________ Attorney Phone #: ______________________

Was this injury a result of a Work-Related Injury (Y/N): _________ Date of Injury_________________

Employer's Name: _______________________________ Employer's Phone #: _____________________________

Name of Insurance Carrier: ____

Case Adjuster Name: ___________________________________ Case Adjuster Phone: ________________________

How did you hear about TTN? ____

Who referred the patient to TTN: ____

Body Part(s) being treated: ____

Patient Signature:____ Date:_______________________

TTN FDC/PCR Initials:__________________ Date: _______________________

The Therapy Network
TTN

MEDICATION LIST

Patient Name: ____ Account # _________________ DOB: _____________

Please list all current medications with name, dose, frequency. Include over the counter medications and supplements.

Date: ____

NAME OF MEDICATION	DOSE	FREQUENCY

Vitamin D: _____ Yes _____ No

PATIENT NAME: ____ ACCT #: _____________________ DOB:______________

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: ____ **ID Number:** ________________________________

Date of Birth: ____ **Daytime Phone #:** ___________________________

Person/Organization providing the information:

____
____
____
____

Person/Organization Receiving the Information:

____
____
____
____

Specific description of information (including date(s)):

____
____

The information described above will be used or disclosed for the following purpose(s):

____
____

Expiration date: ____

To be completed if provider requests the disclosure for marketing purposes:

Circle as appropriate: The Therapy Network **will /will not** receive direct or indirect remuneration from a third party.

To be completed by the patient or personal representative

- I hereby authorize the use or disclosure of my protected health information as described above.
- I understand that this authorization is voluntary.
- I understand that my ability to obtain treatment will not be affected if I do not sign this form, unless that treatment is for a fitness-for-duty evaluation or a research-related treatment.
- I understand that the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics.
- I understand that if the organization authorized to receive the information is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and will no longer be protected.
- I understand that I have a right to revoke this authorization by sending written notification to: *Privacy Officer, 1450 Kempsville Road, Suite 102 Virginia Beach, VA 23464.* Any revocation will not affect disclosures made prior to Practice's receipt or knowledge of the revocation.
- I understand that I have a right to inspect and receive a copy of the information described on this form. I certify that I have received a copy of this authorization.

____ ______________________________

Signature of patient or patient's representative **Date**

____ ______________________________

Printed name of Patient/ Patient's representative **Relationship to Patient**

PATIENT NAME: ______________________________________ ACCT #: ____________________ DOB:____________

Cancellation and No Show Policy

We are committed to improving your health. For the best outcomes it is important that you also have a commitment to the care you need.

Your adherence to the recommended treatment, both frequency and duration is a vital component of your progress with our services; therefore, we have a policy regarding Late Cancellations and Missing Appointments.

Cancellation with more than 24-hour notice: Please call our front desk and speak with a Front Desk Coordinator so that your treatment protocol can be updated and your appointment rescheduled. There will be no fee incurred if you call at least 24 hours before your scheduled appointment time.

Cancellation without 24-hour notice: Please call our front desk and speak with a Front Desk Coordinator so that your treatment protocol can be updated and your appointment rescheduled. A fee of $25.00 will be incurred if you do not call at least 24-hours prior to your scheduled appointment. This fee is not covered by insurance, is the responsibility of the patient/guarantor, and is due before your next treatment.

No Show: Any appointment not kept without notice will incur a fee of $50.00. This fee is not covered by insurance, is the responsibility of the patient/guarantor, and is due before your next treatment.

Emergency situations will be considered. Please contact our Front Desk Coordinator if you have any questions.

My signature below represents my full understanding and acceptance of the policy outlined above.

Signature: ____ Date: _________________________________

Staff Witness: _______________________________________ Date:__________________________________

PATIENT NAME: ____ ACCT #: _____________________ DOB:_____________

Agreement for Health Insurance Information for patients using Medical Services Lien with Attorney

I, ______________________________ _______________ am being treated at The Therapy Network for injuries sustained in an accident on ___________________________________(date).

I understand that in order to appropriately process my account, The Therapy Network will need to obtain my Health Insurance coverage status.

In addition, I have engaged an attorney to handle all legal and financial claims related to said accident.

PLEASE CHOOSE ONE of the following two options:

☐ **I am NOT covered by a health insurance policy that the Therapy Network can bill for payment of medical services rendered as a result of this accident. The cost for these services will be my responsibility regardless of settlement or non-settlement.** ______ **(initial)**

☐ **I am covered by a health insurance policy.** _______**(initial)**

Plan: ____**ID:** ___________________________

☐ I understand that The Therapy Network **DOES participate** with this plan and will file claims to this plan for payment. I am responsible for the payment of all deductibles, co-pays and co-insurance as directed by my plan and will pay these:

□ at the time of service _______ (initial)
□ under a payment plan _______ (initial)

☐ I understand that The Therapy Network **DOES NOT participate** with this plan and WILL NOT file claims to this plan for payment. I am responsible for the payment of all charges and will pay these:

□ at the time of service _______ (initial)
□ under a payment plan _______ (initial)

I understand that most health insurance plans require timely filing of all claims within 90 days to 12 months of each date of service.

I understand that should any of the above change at a future time, subsequent to the execution of this document, examples being loss, gain or change of health insurance coverage, I must notify the Therapy Network in writing, and present this written request in person to the management staff of the Therapy Network at the clinic office where I am receiving medical care.

I have read and understand this agreement with The Therapy Network.

____ ________________________________
Signature Date

____ ________________________________
Printed Name Date

Staff Initials: ________________________________ Date: __________________________

PATIENT NAME: ____________________________ ACCT #: _______________ DOB:__________

IRREVOCABLE ASSIGNMENT OF BENEFITS, AUTHORZATION AND LIEN

To Whom It May Concern:

This Irrevocable Assignment of Benefits, Authorization and Lien (this "Assignment") is made by and between ______________________________ (patient) and THE THERAPY NETWORK hereinafter referred to in the singular as ("Provider"). With this Assignment, and in consideration of treatment without having to render concurrent payment, Patient, hereby irrevocably transfers, sets over and assigns to Provider all insurance and/or litigation proceeds to which Patient is now or may hereafter become entitled, including those listed below , up to the total amount due and owing the Provider for services rendered to the Patient by reason of accident or illness, including interest thereon, as well as any other charges that are due or may become due the Provider, including, without limitation, requested reports, collections costs and expenses and attorneys' fees, and Patient further hereby irrevocably authorizes and directs any insurance company and/or attorney to whom an original or copy of this assignment is provided to withhold from Patient and pay directly to such Provider such amount(s) from (1) any insurance benefits payable to Patient or on Patient's behalf, including, but not limited to, medical payments benefits, No Fault benefits, health and accident benefits, foundation grants, governmental or agency benefits, worker's compensation benefits or an other insurance proceeds or benefits of any kind which are payable to or on behalf of the Patient, and (2) any litigation proceeds (which may include insurance proceeds) from any settlement, judgment or verdict in Patient's favor as may be necessary to fully pay any and all financial obligations owed to the Provider by the Patient. The Assignment is to be a complete and current transfer of Patient's right, title and interest, separate from any statutory or contractual lien or claim to which the Provider may also be entitled. Patient acknowledges that Provider has a substantial pecuniary interest in the enforcement of this Assignment.

This assignment is intended to be effective as of the date the Provider first treats the Patient.

The Patient agrees that, in the event the insurance company and/or attorney obligated hereunder to make payments to the Provider fails or refuses to make payment for the full amount due as set forth above, this Assignment is a full, immediate and complete assignment of all of the Patient's rights, title, interest, remedies and benefits in and to the assigned property to the extent of the Provider's total claim amount; therefore, Patient hereby irrevocably and fully assigns and transfers to the Provider any and all causes of action that Patient might have or that might exist in Patient's favor against such insurance company and /or attorney, with respect to the assigned property. In addition to the foregoing assignment, Patient hereby authorizes nominates and appoints as Patient's attorney-in-fact any officer of the Provider, to prosecute said cause(s) of action either in Patient's name or in the Provider's name and Patient further authorizes the Provider to compromise, settle or otherwise resolve said claim(s) or cause(s) of action as it sees fit.

In further consideration of the services provided by the Provider, if irrevocable assignment of insurance benefits and / or litigation proceeds is invalid for any reason, Patient hereby grants a lien to said Provider against any and all insurance benefits and litigation proceeds outlined in the first paragraph above which may be payable to or on behalf of the Patient as a result of the injuries or illness for which Patient has been treated by said Provider. The Patient further agrees that the statute of limitations applicable to the Provider's right to demand payment from the Patient shall be tolled for all reasonable times that negotiations or litigation between third parties and the Patient are ongoing.

Patient hereby acknowledges that Virginia law imposes a lien in the amount of $750.00 upon Patient's claim against the individual or entity whose negligence is alleged to have caused Patient's injuries. Notwithstanding the foregoing, the Patient agrees that until the Provider is paid in full, the Patient shall remain personally and fully responsible for and promises to pay the total amount due the Provider (including principal, interest, collection costs and attorney's fees of 35%) until fully paid. The Patient further understand and agrees that this Assignment does not constitute any agreement of or consideration for Provider to await payments from any source, and in the event the Provider deems itself in it's sole discretion insecure as to the prospect of payment, it may demand payments from Patient immediately upon rendering services at its option and proceed to collect same through legal means if necessary.

Patient authorizes the Provider to release this Assignment and any information pertinent to Patient's case to any insurance company, adjuster or attorney to facilitate collection under this Assignment. Patient hereby nominates and appoints any officer of the Provider as Patient's attorney-in-fact to endorse/sign Patient's name on any and all checks for payment of the services provided to the patient by said Provider.

PATIENT NAME: ______________________________ ACCT #: ____________________ DOB:____________

In the event that any part or provision of this Assignment shall be determined to be invalid or unenforceable, the remaining parts and provisions of this Assignment which can be separated from the invalid, unenforceable provision shall continue in full force and effect.

Notice: Automobile accidents. If you have been in an automobile accident, you may be entitled to payment from your automobile insurance if you have medical expense coverage benefits. By your signature on this assignment you are giving to your provider the right to receive some or all of that payment directly from your automobile insurance company. If you have health insurance and your Provider is in- network: as long as you provide the information necessary to verify your health insurance coverage the Provider may only -bill the amount you owe for any co-payment, co-insurance, or deductible to your automobile insurance and you may be entitled to any remainder of your automobile insurance benefit. If you do not provide information necessary to verify your health insurance coverage, do not have health insurance, or your Provider is not in your insurer's provider network: your Provider may bill their full charges to your automobile insurance.

You may want to consult your insurance agent or attorney before signing or initialing this form.

Patient acknowledges that as a courtesy Provider may choose to bill Patient's insurance, including but not limited to Patient's secondary insurance and Patient's automobile insurance, but the provider is not required to do so.

Patient Acknowledges that 1.) Patient shall remain responsible for any amounts not paid for or covered by any medical expense benefit coverage and 2.) all of Providers charges are the usual and customary fees charged in this community for health care services rendered. Patient further acknowledges that Provider does not have a Provider Agreement with any medical payments coverage insurance carriers and is not bound by any determination by medical payments coverage insurance carriers as to what the amount of a usual and customary fee charged in this community for health care services rendered.

YOUR ARE NOT REQUIRED TO EXECUTE THIS ASSIGNMENT IN ORDER TO RECEIVE CARE.

However, if you do not sign this form, you will be required to pay for all care at the time of service.

By initialing here, I acknowledge that I have read or had the opportunity to read this notice. Patient Initials: _________

PATIENT

Signature: ____________________________
Printed Name: ____________________________
Date: ____________________________________

PROVIDER REPRESENTATIVE/WITNESS

Signature: _________________________
Printed Name: ______________________
Date: ______________________________

Attorney Acknowledgement

Attorney for Patient (if applicable)

Name: ____

PATIENT NAME: __________________________________ ACCT #: ____________________ DOB:____________

Acknowledgement of Practice Policy, Procedure and Consent

Please carefully review these policies and initial each section where indicated.

Financial Information ***Initial:*** ________

Payment is due at the time services are rendered unless other payment arrangements have been made. The patient/guarantor is ultimately responsible for payment of all services rendered up to and including collection and attorney fees.

Special Reports and Copies of Records ***Initial:*** ________

There is a nominal charge for the preparation and copying of medical records. There is a fee for specially requested reports or letters not related to treatment record keeping.

Authorization and Assignment ***Initial:*** ________

As a courtesy, TTN will file claims for treatment to the health insurance carrier on record. I hereby give my carrier permission to send payment to TTN and TTN permission to provide my carrier with information required to process my claims.

Missed Appointment Charges ***Initial:*** ________

I will be responsible for payment of any fees incurred as a result of scheduled appointments missed or cancelled without at least 24-hours notice. Payment is due prior to the next scheduled appointment.

Privacy Notice ***Initial:*** ________

I have received a copy and/or a copy has been made available to me of the Privacy Notice for The Therapy Network and I understand and agree to the contents.

Consent to Treat ***Initial:*** __________

This consent provides us with your permission to perform reasonable and necessary examinations and testing in order to determine a course of treatment.

Deemed Consent ***Initial:*** ________

I understand that if a healthcare provider or staff member at The Therapy Network is exposed to my blood or other bodily fluids in a manner which may transmit disease, I may be tested for infection with Human Immunodeficiency Virus (HIV), the virus which causes Acquired Immune Deficiency Syndrome (AIDS) or Hepatitis B or C viruses. I further understand that the results of any such test will be shared with me and the exposed healthcare provider or staff member; that the Virginia Department of Health will be notified; and the appropriate counseling shall be provided if the results are positive.

Patient Authorization ***Initial:*** ________

I authorize photocopies of this form to be as valid as the original.

Patient Signature: ____ **Date:** __________________

Provider Representative/Witness: _________________________________ **Date:** _________________

PATIENT NAME: _________________________________ ACCT #: _____________________ DOB:______________

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language regarding applicable state law requirements as appropriate*]

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the State Corporation Commission's (SCC) Bureau of Insurance. To contact the SCC for questions about this notice visit: scc.virginia.gov or call: 1-877-310-6560. .

Visit *https://thetherapynetwork.com/surprise-billing-act* for more information about your rights under federal law.