Welcome!

Welcome and thank you for choosing Dynamic Spine & Sport Rehabilitation! Our passion is to restore your health and get you back to the life you were living through manual based therapy as well as a complete and holistic treatment of the mind and the body. Our clinicians will provide you with quality care in a warm and inviting environment. We hope you enjoy your experience!

We want to know! Do you have a Primary Care Physician (PCP)? If not, please e-mail **jenna@dynamicspinesport.com** to be referred out today.

All patients must complete and sign the entire patient registration packet before they can be seen by the physical therapist.

Please Read Below

Insurance Information: We need complete and accurate information about your policy. If you have secondary insurance, please provide us with that as well. We will submit claims to your health insurance company for you. You are responsible for all out-of-pocket expenses as determined by your contracted rate with your insurance company. You are also ultimately responsible for any services not covered by your insurer.

Changes in Coverage: It is your responsibility to inform us of any and all changes of insurance coverage during the course of treatment. Failure to do so may result in denial of coverage by your insurance company.

Review Your "Schedule of Benefits": We urge you to review your insurance policy's "Schedule of Benefits"! It will help you understand the agreement you have with your insurance company. You should call your insurance company with any specific questions related to your policy relating to outpatient physical therapy benefits. You need to accurately verify and understand your policy's deductible, co-payment, co-insurance, visit limits, effective annual calendar renewal date, and any pre-authorization requirements. As a courtesy we will also verify your coverage, but we will not guarantee the accuracy of the information we receive. Your insurance policy is a contract between you and your insurance company. You are responsible to know your level of coverage and you are ultimately responsible for the full payment of your bill.

In-Network: You are responsible for meeting the in-network deductible, if any, before your insurance will begin to reimburse for the services rendered. You are responsible for co-payments and/or coinsurances as specified in your "Schedule of Benefits." DSSR has agreed has contracted with your insurance company to accept the maximum allowable charge as full payment for the services rendered. There will be no balance billing for covered services. You are responsible to pay for any services that are received but not covered under your policy. Co-pays or deductible are due at the time of service.

Out-Of-Network: You are responsible for meeting the out-of-network deductible, if any, before your insurance will begin to reimburse for the services rendered. You are responsible for co-payments and co-insurances. You are also responsible for the difference between billed charges and your insurance company's maximum allowable charges. Your out-of-network benefits for outpatient physical therapy will be clearly explained in your insurance policy's "Schedule of Benefits". We will submit claims for payment to your insurance company. DSSR requires a minimum payment of $70.00 per session for patients who have and out-of-network insurance policy. This payment will be applied towards your balance.

Non-Insurance-Fee-For-Service: Fee-for-service is exclusively a non-insurance financial arrangement. The Fee-for-service arrangement is exclusively separate from the In-Network an Out-of-Network scenarios. Fee-for-Service receipts cannot be submitted to insurance for reimbursement. To be eligible for this discount, full payment must be received for the services rendered at this time of service.

Worker's Compensation: If you are claiming worker's compensation you must provide us with a copy of your personal insurance card and a letter from your worker's compensation insurance carrier. We will confirm your authorization with your case adjuster or case manager. In the event payment for your claim is denied by your worker's compensation carrier, we will file the claims with your personal insurance policy. If your claim is denied by your personal insurance, you are responsible for the full payment of your bill.

Medicare: DSSR is a Medicare approved provider of outpatient physical therapy. All Medicare policy holders need to have a physician's referral or prescription prior to starting as a physical therapy patient at DSSR. Your initial physical therapy plan of care must be certified by your physician and if your physical therapy continues beyond 30-days after the date of the first certification, the plan of care will need to be re-certified. It is our responsibility to be sure that that plan of care is certified. This may require you to follow up with your physician more frequently.

Minors: A parent or legal guardian must accompany the minor patient at all times including the initial visit and subsequent treatments. The parent or legal guardian is responsible for full payment as outlined in the above financial policy. If the parents are separated and both legally responsible for the child, you must provide complete information from both parents. The parent or legal guardian that accompanies the minor patient to the clinic will have full responsibility for the payment should any dispute arise.

Personal Injury, Liability, Auto, or Involvement of an Attorney: You need to complete and sign all of the patient registration forms and attorney medical lien paperwork. You must still provide us with a copy of your personal insurance card. We may also need a physician's written referral for these cases. In the event your claims are denied by the liability carrier or that the personal injury protection benefits are exhausted, we will file claims with your personal health insurance policy. If your personal insurance policy denies the claim for any reason, you are responsible for the full payment of your bill.

Statements: Patient statements will be mailed out monthly. As a courtesy, DSSR will submit claims to your health insurance company after each visit and we will apply payments received to your account. Any remaining balance after your health insurance has paid is your responsibility.

Disputes: Our financial policy is designed to promote due diligence and a proactive rather than reactive strategy. With your participation, this policy will minimize and potentially eliminate errors, miscommunication and bad information with regard to your insurance or other financial arrangement for payment. We will not become involved in disputes between you and your insurance company regarding, but not limited to, deductibles, co-insurances, co-payments, covered services, pre authorizations and usual and customary charges.

Payment: We accept cash, check, VISA, MasterCard and American Express. There will be a $35.00 service charge for all returned checks. If you have insurance, balances will be considered current from the date your insurance pays its portion. After that, there is a 90-day grace period to pay your portion of the services. We will work with you to setup a customized payment plan if necessary, just ask!

Collections: We will work with you to avoid sending your account to collections. In the event of default on your account, your account will be turned over to a collection agency. You will be responsible for the unpaid balance and an additional 35% service charge based on your unpaid balance.

Appointment Policy: When canceling you must call at least one (1) business day in advance of your scheduled appointment. We reserve a 1-hour appointment on our schedule for your appointment and we appreciate an advanced notice so that another patient may schedule during that time slot. If you fall to call 1 business day in advance, you will be assessed a $35.00 cancellation fee that is not billable to insurance. If you "no-show" an appointment you will be assessed a $35.00 no-show fee. We understand that there are special and unforeseen situations that will be assessed on a case-by-case basis.

Non-Covered Services: Throughout the course of your treatment, you may need other therapeutic supplies recommended by your physician or physical therapist. DSSR will not submit claims for other therapeutic supplies to your insurance company. Therefore, full payment for these supplies is due at the time of service or purchase. You may submit the receipt for these purchases on your own to your health insurance company.

Consent to Physical Therapy Evaluation and Treatment

I hereby consent to evaluation and/or treatment of my condition by licensed physical therapist employed by or under contract with Dynamic Spine and Sport Rehabilitation.

The physical therapist has fully explained to me the nature and purpose of the procedures, evaluation and course of treatment, and has witness my signature of this consent in his or her presence.

The physical therapist has informed me of expected benefits and possible complications or discomfort, which may result from skilled physical therapy care. In addition, the physical therapist has explained to me the risks of receiving no treatment.

The physical therapist has explained that there is no guarantee that the proposed course of treatment will improve my condition and that is possible, although unlikely, that the course of treatment may cause addition pain or discomfort or aggravate my condition. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent form.

Patient/Guardian Name: ____ Date: _______________

Patient/Guardian Signature: ____

Relationship of Guardian: ____

Authorization for Release & Discoluse fo Protected Health Information

Patient Name: ______________________________________ **Account #:** ____________________

In accordance with state law and regulatory agency requirements, this health record is the property of Dynamic Spine & Sport Rehabilitation (DSSR). I hereby authorize the DSSR Medical Records Custodian to release/obtain information from the medical record of:

From:

Name: _________________________________
Address:_______________________________
City/State/Zip:__________________________
Phone:_________________________________

Information May Be Released To:

Name: _________________________________
Address:_______________________________
City/State/Zip:__________________________
Phone:_______________________________

Please Release The Following Information:

__ Problem List
__ Progress Notes
__History/Physical
__Medications

__ X-ray Reports
__ X-ray Films
__EKG Reports
__Other Reports (Specify) ____________________________________

__ Mental Health
__ Drug/Alcohol
__Lab Reports

__ Outside Records
__ Immunizations
__HIV/AIDS Test

This information is necessary for the following purpose:

_____Cont. Patient Care _____Personal Use _____Attorney/Legal ______Insurance

_____Other (Specify) ____

I understand that the information in my health records may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol/drug abuse. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy, unless otherwise revoked. This authorization will expire on the following date, event, or condition: ____________________. If I fail to specify an expiration date, event or condition this authorization will expire in twelve (12) months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not to sign this in order to assure treatment. I understand that with certain exceptions I may inspect or copy the information to be used or disclosed. I understand that a disclosure of information carries with it the potential for a unauthorized re-disclosure and the information may not be protected by federal confidentiality rules If I have any questions of my health information I can contact.

Patient/Guardian Signature: ____ Date: _______________

Relationship of Guardian: ________________________________ Witness: ___________________________

With respect to clients, receiving chemical dependency services this information has been disclosed to you from records protected by Federal Law 42 USCA Sec. 290-dd (2). Federal law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Federal Law 42 USCA Sec. 290-dd (2).

Legal Irrevocable Assignment of Benefits & Release of Medical/Authorized Rep

In considering the amount of expenses to be incurred I, ____,
The undersigned have insurance and/or employee health care benefit coverage with
____ (Insurance Company information), and hereby irrevocably assign and convey directly to **Joseph Indrieri, MSPT, DPT/Dynamic Spine & Sport Rehabilitation** (hereafter "provider") all right, title and interest in all medical benefits payable and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider/practice. Said irrevocable assignments and transfer shall be for the purpose of granting the provider/practice an independent right of recovery against such responsible parties, but shall not be constructed to be an obligation of the provider/practice to pursue any such right to recovery. I hereby authorize all responsible parties to pay directly to the provider/practice all benefits and amount due for services rendered by the physician.

I understand that if the provider/practice is not paid in full by proceeds for any benefits, then this assignment does not release my obligation and liability to the provider/practice for payment and all services and items provided to me or by my insurance company or employee health benefit plan, then I agree to pay provider/practice for all charges in excess of the benefits paid. All payments will be made to provider/practice at: **8951 W Sahara Ave., Ste. 190 Las Vegas, NV 89117-5898.**

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider/practice any and all summary plan documents, insurance policy and/or settlement information upon written request from such provider/practice in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider to the full extent permissible under the law and under any applicable insurance policies and /or employee health care plan any claim, chosen action, or the right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expense incurred as a result of the medical services I received from the above name provider/practice and to the extent permissible under law to claim such benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such provider/practice in any attempts by such provider/practice to pursue such claim, chose action or right against any insurers and /or employee health care plan, including, if necessary, bring suit with such provider/practice against any insurers and/or employee health care plan in my name but as such provider/practice's expense.

This lifetime assignment of benefits will remain in effect until revoked by me in writing. A photocopy of this assignment of benefits is to be considered as valid as the original.

The terms and consequences of these irrevocable assignments and financial responsibilities have been fully explained to me to my understanding and I have signed this document freely and without inducement other than the rendition of services by the physician.

Name of Insured/Responsible Party: ____

Signature of Insured/Responsible Party: ____

Date: ______________________________

Acknowledgement Form

Please note that by signing this form, you have read, understand and agree to DSSR office policies.

Please Initial:

________1. **HIPAA Compliance Policy and Notice of Privacy Rule**: Mandated by the Federal Government, summary of your rights, rules and regulation about privacy related to your medical health records.

________2. **Office and Financial Policy**: Our policy regarding to insurance, payment, collections and appointments.

________3. **Assignment of Benefits and Authorized Representative**: A legally binding agreement between you and your insurance company asking them to send your reimbursement and authorization to represent you on your behalf.

________4. **Consent to Treat**: Voluntary. Informed consent for treatment.

________5. **Collections**: In the event of a default on your account, your account will be turned over to a collection agency. You will be responsible for any unpaid balance as well as a 35% service charge.

Patient/Guardian Name: ____ Date: _______________

Patient/Guardian Signature: ____