Welcome to SIMIO Health Services! To help prepare you we have compiled a list of items you will need at your first visit.

- **Insurance Card**
- **Drivers License**
- **Physicians prescription/referral (if not in SIMIO possession)**
- **Completed Paperwork (attached)**
- **Walking shoes and loose comfortable clothing**

Please arrive **15 minutes early** to your first appointment. If you have any questions please call 616-796-6781 M-F 8am to 5pm.

We look forward to meeting you,

SIMIO PT

Notice of Privacy Practices

Uses and disclosure of your Health Information

TREATMENT. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of evaluations will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

PAYMENT. Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

HEALTH CARE OPTIONS. Your health information may be used as necessary to support the business activities of SIMIO Health Services. For Example, information on the services you received may be used to support budgeting and financial reporting, and activities to improve quality or training.

LAW ENFORCEMENT. Your health information may be disclosed to law enforcement agencies without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

PUBLIC HEALTH REPORTING. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

APPOINTMENT REMINDERS. Your health information will be used by our staff to send you appointment reminders.

INFORMATION ABOUT TREATMENTS. Your health information may be used to send you information on the treatment and management of your medical condition or new technology that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

Your Health Information Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your health information.
- The right to amend and/or submit corrections to your health information.
- The right to receive an accounting of how and to whom your health information has been disclosed.
- The right to receive a printed copy of this notice.

Our Health Information Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and the practices that are outlined in this notice.

Our Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. The revised policies and practices will be applied to all protected health information that we maintain and will be available at our facility for you upon your request.

Requests to Inspect Protected Health Information

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our office.

Complaints

If you would like to submit a comment or complaint about our privacy practices, or if you believe your privacy rights have been violated, you can contact SIMIO Health Services by sending a letter outlining your concerns. You may also file a written complaint with the Office of Civil Rights.

Patient Information Form

Personal Information

Prefix: ____ Last Name: __________________ Suffix: ______ First Name: _____________ MI: ___

Social Security Number: ________-_______-_________ Date of Birth: __________________

Address: ___________________________________ Email: _________________________________

City: ___________________________________ State: _______ Zip: ___________________

Home Phone: ___________ ☐ Cell Phone: ____________ ☐ Work Phone: _______________ ☐

(Check box if OKAY to leave voicemail)

How did you hear about SIMIO Health Services? ____

Emergency Contact information

Last Name: ____________________________ First Name: __________________ MI: _______

Relationship: ☐ Spouse ☐ Parent ☐ Friend ☐ Other

Home Phone: ___________ Cell Phone: ____________ Work Phone: _______________

Primary Physician

Primary Physician Name: ______________________ Referring Physician: _____________________

Insured Party/Responsible Party (Leave blank if same as patient)

Prefix: ____ Last Name: __________________ Suffix: ______ First Name: _____________ MI: ___

Social Security Number: ________-_______-_________ Date of Birth: __________________

Address: ___________________________________ Email: _________________________________

City: ___________________________________ State: _____________ Zip: ___________________

Home Phone: ___________ ☐ Cell Phone: ____________ ☐ Work Phone: _______________ ☐

Relationship to Patient: ___________________________

Patient Employer Information

Employer Name: ____

Financial Policy/Payment Assignment and Guarantee

SIMIO Health Services firmly believes that a good patient relationship is based upon understanding and good communication. Questions about our financial policy or payment arrangements should be directed to the business office.

Our office participates with a variety of insurance plans. If you are a member of one of those plans, our business office will submit a claim for services. It is your responsibility to:

- Provide us with current insurance information (including your social security number) and bring your insurance card and driver's license to your 1st appointment.
- Be prepared to pay your co-pay, co-insurance or service charge at each visit. Pay any balance not covered by your insurance plan including deductibles.
- Provide workers compensation or accident related coverage (Including Claim Number) to allow us to bill the proper location for your services.

Patients with outstanding balances will receive monthly statements. Payment of the outstanding patient balance is expected within 30 days of receipt of statement. Patient balances over 45 days will receive letters reminding of unpaid balances. If there is a patient balance over 90 days we will contact you directly about payment options.

Certain modalities require additional service charges. These charges are due at the time of service. You therapist will explain the necessity and service charge for each modality prior to administering the service.

For any patient that is a minor the parent or guardian must sign below. The parent, guardian of the minor is responsible for payments due at the time of service.

Assignment: I authorize release to any third party, such as insurance company or governmental agency, any medical information when such material is required for consideration or payment. I assign all payments for medical services for myself and/or dependent to SIMIO Physical Therapy. I agree to pay any charges for the patient listed not covered by my insurance.

____________________	________________________	__________
Patient Name	Signature of Responsible Party	Date

Designated Individuals Authorization Form

I understand I have the right to authorize additional people to discuss my medical records (anyone OTHER THAN your physician, insurance company, Workman Compensation Carrier or Employer). I hereby authorize the release of any protected health information by SIMIO Health Services to the parties listed below.

AUTHORIZED DESIGNEES:

Name: ____________________________ Relationship: ______________________

Name: ____________________________ Relationship: ______________________

Name: ____________________________ Relationship: ______________________

____________________	________________________	__________
Patient Name	Signature of Responsible Party	Date

MEDICAL HISTORY

Patient Name: ___________________________ Date of Birth: _________________

Reason for your visit (diagnosis): ____

When did your symptoms begin? __________________ Auto or Work related? __________________

Are you currently receiving any other care for the condition mentioned above? ☐
If Yes please list:

Have you ever received therapy in the past for this condition? ☐ IF Yes When: ______________

Have you received therapy services for other problems conditions in the past year? ☐
If Yes please list:

At the present time would you say that your health is: ☐ Excellent ☐ Very good ☐ Fair ☐ Poor

Do you now have or have you ever had any of the following? Please check if Yes, leave blank if No.

Condition	Condition	Condition
☐ Arthritis	☐ Diabetes	☐ Thyroid Problems
☐ Osteoporosis	☐ Anemia	☐ Headaches
☐ High Blood Pressure	☐ Sensitivity to heat/cold	☐ Head Injury / Concussion
☐ Heart Disease	☐ Swelling Ankles	☐ Hernia
☐ Heart Attack	☐ Deep Vein Thrombosis	☐ Kidney / Bladder Problems
☐ Pace Maker	☐ Seizures / Epilepsy	☐ Previous Fractures
☐ Vascular Disease	☐ Metal / Surgical Implant	☐ Previous Surgery
☐ Stroke	☐ Cancer / Tumor	☐ Hearing Loss
☐ Asthma	☐ Recent Weight loss / gain	☐ Depression
☐ Shortness of Breath	☐ Current Infection(s)	☐ Anxiety
☐ Chronic Cough	☐ Tuberculosis	☐ Substance Abuse
☐ Allergies	☐ Currently Pregnant	☐ Are you currently taking prescribed Medications
☐ Fainting Spells	☐ Hepatitis	☐ Other

Please describe below all YES responses and give dates:

____

____

____

____

Please list all current prescribed medications:

____

____

____

____

With my signature below I certify that all the information provided herein is true and correct.

____ _____________

Patient/Guardian Signature Date

CONSENT FOR TREATMENT

I hereby voluntarily consent and give authorization to receive treatment at SIMIO Physical Therapy. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing and treatment. No Guarantees have been made to me about the outcome of this care.

Initial: _______________

PATIENT INFORMATION

I have read and fully understand SIMIO Physical Therapy's Notice of Privacy Practices. I understand that SIMIO Physical Therapy may use or disclose my personal health information for the purpose or carrying out treatment obtaining payment, evaluating the quality of service provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the company in writing. I also understand that SIMIO Physical Therapy will consider requests for restrictions on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purpose noted in SIMIO Physical Therapy Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the company in writing at any time.

Initial: _______________

RECOGNITION OF RIGHTS REGARDING STUDENTS AND OBSERVERS

I understand that SIMIO Physical Therapy is a teaching facility with affiliation to many area schools including GVSU's DPT program. At various times of the year, students will be present during my treatment and may provide care under the direction and supervision of a licensed physical therapist. This is necessary for students and physical therapists to receive excellent training to continue SIMIO's mission to provide the highest quality care. I have the right and option to a private treatment session without a student or observer present, and/or have the right to allow the observer to be present in the session, but not be physically involved in my treatment. This request should be voiced to the business manager and/or your physical therapist at any time during any visit.

Initial: _______________

BENEFIT VERIFICATIONS

The information (e.g. benefits, limitations, deductibles, co-pay, co-insurance) obtained by SIMIO Physical Therapy from your insurance company is limited. For this reason, any explanation of benefits relayed or discussions of potential costs is an estimate and not a certification of benefits nor a guarantee of payment. Determination of insurance payment and patient responsibility for services rendered will be finalized by your insurance company per your individual policy.

I understand that my health and accident insurance policies are an agreement between me and my insurance company and not between my insurance company and SIMIO Physical Therapy. I understand that SIMIO Physical Therapy encourages that I contact my insurance company to verify all shared information (e.g. benefits, limitations, deductibles, co-pay, co-insurance). I understand that SIMIO Physical therapy has no control over the contract between me and my insurance company.

Initial: _______________

CONSENT SIGNATURE

I, ____________________________________ have read and understand the information provided above.
(print full name)

Patient/Guardian Signature: ____ Date: _______________

SIMIO
HEALTH SERVICES