CORNERSTONE
THERAPY AND BALANCE CENTER

Authorization for Release of Information

Section A (Must be completed for all authorizations):

I hereby authorize the use of disclosure of my identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ DOB: _____

Persons/Organizations **providing** the information: _____

Persons/Organizations **receiving** the information: __Cornerstone Therapy and Balance Center__

Description of information, including dates: _____

Section B (Must be completed only if a health plan or a health care provider has requested the authorization):

1) The health plan or health care provider must complete the following:
   - **a.** What is the purpose of the use or disclosure? _____
   - **b.** Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? ___Yes ___No
2) The patient or the patient's representative must read and initial the following statements:
   - **a.** I understand that my health care and the payment for my health care will not be affected if I do not sing this form. Initial: _____
   - **b.** I understand that I may see and copy the information described on this form if I ask for it and that I can get a copy of this form after I sign it. Initial: _____

Section C (Must be completed for all authorizations):

The patient or the patient's representative must read and initial the following statements:

_____ I understand that his authorization will expire on ___/___/_____.

_____ I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it will not have any effect on actions before receiving the revocation.

This form must be completed BEFORE patient signature is requested.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Printed Name of Patient or Patient's Representative Relationship to Patient

You May Refuse to Sign this Authorization

8961 Youree Drive, Shreveport, LA 71115
Phone: (318) 671-8772 ♦ Fax: (318) 671-8776

Acknowledgement of Receipt of
Notice of Privacy Practices and Nondiscrimination Policy

Cornerstone Therapy and Balance Center reserves the right to modify the privacy practices and nondiscrimination policy outlined in the notices. For more detailed information, a copy of our Practices and Policy is available upon request.

I have received/ viewed a copy of the Notice of Privacy Practices and Nondiscrimination Policy for Cornerstone Therapy and Balance Center.

I have been offered a paper copy, and I have:

Accepted. Refused this copy.

Patient's Name (Please Print): _____

Patient's Signature: _____

Date: _____

Signature of Patient's Representative

If patient is a minor or an adult who is unable to sign this form, patient's representative will sign below.

Patient's Representative Printed Name: _____

Patient's Representative Signature: _____

Relationship to Patient: _____

Date: _____

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Consent and Method to Confirm Your Appointment

Health Insurance Portability & Accountability Act (HIPAA) is a federal law passed in 1996 which requires healthcare organizations to comply with specific rules. One of these rules governs the disclosure of your medical information. Because of these regulations, we much have your permission to release any medical information to someone other than yourself.

It is our policy not to release confidential and/or unauthorized information until you have authorized such disclosure. When we return your telephone calls or confirm your appointment, we can only leave messages in methods listed and with people you have authorized. An authorized person is one to whom you have given us permission to speak with. The following information provided is our authorized information for you:

I authorize Cornerstone Therapy and Balance Center to leave appointment reminders by the preferred method listed below.

Your appointment will be confirmed by an automated voice message or a text message. Please check your preferred method.

	Please list contact information	Preferred
Home Telephone		□
Work Telephone		□
Cell Phone		□
Text Message		□

Please list the names and relationships of authorized people below:

_____
_____
_____
_____
_____

Patient Name (Please Print): _____

Patient Signature: _____

Date: _____

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Appointment Cancellation Policy

We are committed to exceptional customer service and clinical care to expedite the healing and recovery process. To accomplish this, it is extremely important that you attend each of your scheduled appointments. We value your appointment and this time slot is specifically set aside for you.

Failure to keep your scheduled appointments at Cornerstone Therapy and Balance Center hinders our ability to provide the best care to our patients. To limit missed appointments, we have implemented a "No-Show/Late Cancellation Fee."

We ask that you show us consideration by calling at least 24 hours prior to your appointment if you are unable to attend. This will allow us the opportunity to offer that appointment to another patient. Please call Cornerstone Therapy and Balance Center at **(318) 671-8772**.

- We require a 24 hours advanced notice of appointment cancellation.
- In the event of a late cancellation or "no-show," your account will be assessed a **$25 cancellation fee**.
- Three (3) cancellations or no-shows during the course of therapy requires your therapist to discharge you from therapy. In the event that you are discharged from our care, your referring provider or case manager will be notified of the reason for discharge from physical therapy.
- Workers' Compensation patients are not charged for cancellations or no-shoes; however, we are required to notify the patient's physician, case manager, and employer of non-compliance with therapy.
- Late cancellations due to illness or family emergency are excluded from this policy.

At Cornerstone Therapy and Balance Center, failure to give a 24 hour notice prior to cancellation will result in a "No-Show/Late Cancellation Fee." This fee cannot be billed to your insurance company and will be your direct responsibility.

The No-Show/Late Cancellation Fee is as follows:

Physical/Occupational Therapy Appointments No-Show/Late Cancellation Fee—$25.00 is to be paid at the time of next visit.

I understand Cornerstone Therapy and Balance Center's appointment cancellation policy and I understand my responsibility to plan appointments accordingly and notify Cornerstone appropriately if I have difficulty fulfilling my scheduled appointments.

Patient Signature: _____ **Date: _____**

Witness Signature: _____ **Date: _____**

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My Medicines

In the first column, please list the medications you are currently taking. In the second column, please write the reason why you are taking it.

Medication Name	Reason

Patient's Name: _____ Date Completed: _____

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The Patient's Rights

You have the right to:

- Be fully informed about your rights and responsibilities as a patient and about services available and charges for those services.
- Be treated with dignity and respect.
- Privacy in your treatment and confidentiality of your medical records.
- Know about your physical condition and to receive information necessary to give informed consent prior to the start of treatment.
- Voice opinions, recommendations, and grievances in relation to services offered by the facility and policies without fear of discrimination or reprisal.
- Refuse treatment to the extent permitted by law and to be informed of the consequences of your refusal
- Refuse participation in research conducted by Cornerstone Therapy and Balance Center.
- Refuse to have photographs taken during your clinical visits.

The Patient's Responsibilities

You will be responsible for:

- Providing accurate and complete information about your health and about your health insurance and/or other applicable information, such as attorney or MVA information.
- Active participation in the development of your treatment plan and in your treatment plan, such as a home exercise program.
- Consideration of the rights of others while in the clinic area.
- Regular and prompt attendance at the appointed times.

Signing below confirms that you have read the patient's rights and responsibilities above.

Patient Signature: _____ Date: _____

Cornerstone Therapy and Balance Center
Patient Information Sheet

Patient Information

Patient Name	Date of Birth	Age	Home Phone No.	Cell Phone No.

Street Address	City	State	Zip Code

Soc. Sec. No.	□ Male □ Female	□ Married □ Divorced □ Separated □ Single □ Widowed	Spouse's Name

Patient Employment and Student Information

Employer's Name	□ Employed full time □ Employed part time □ Retired □ Student full time □ Student part time

Employer's Address	City, State, Zip Code	Employer's Phone Number

Insurance Information

Primary Insurance	Insured's Name and DOB (□ check box if same as patient)

Insured's Relationship to Patient (check box) □ Self □ Spouse □ Parent of Patient	Address of Insured (□ check box if same as patient)

Secondary Insurance	Insured's Name and DOB (□ check box if same as patient)

Insured's Relationship to Patient (check box) □ Self □ Spouse □ Parent of Patient	Address of Insured (□ check box if same as patient)

Are you receiving Home Health Services? □ **Yes** □ **No** Are you Black Lung Entitled? □ Yes □ No

Injury Information (for MVA, Personal Injury, and Workers' Comp.) □ Does Not Apply

Date of Injury and State in which accident occurred:	Type of Injury (Check all that apply): □ Motor vehicle accident □ Work-Related □ Other than MVA

Attorney Information □ Does Not Apply

Do you have an attorney for this injury? □ Yes □ No	Name and Phone number of Attorney:

Worker's Compensation information (if you were injured on the job) □ Does Not Apply

Employer	Employer Contact Person	Employer Phone Number

Address	City	State	Zip Code

Emergency Information

Person to contact in case of Emergency	Phone Number	Relationship to Patient

Responsible Party Information

Person Responsible for Medical Expenses	Relationship to Patient	Phone Number

Address	City	State	Zip Code

Consent - Release - Payment Policy - Read Before Signing

I authorize Cornerstone Therapy and Balance Center to: (1) render treatment to me as ordered by my physician and I grant permission to Cornerstone to obtain my medical records from my physician, (2) furnish information to insurance carriers and/or Medicare, (3) contact my attorney and release information to my attorney. I hereby assign to Cornerstone Therapy and Balance Center all benefits paid on my behalf from insurance carriers and/or Medicare. I understand that in the absence of payable benefits from my insurance carrier and/or Medicare and/or attorney, I am responsible for all charges incurred for my care.

Patient Signature: _____ Date: _____