SOURCE ONE

Village Physical Therapy

Financial/Office Policy

Thank you for choosing us for your healthcare needs. We are committed to providing you with quality and affordable healthcare. The following is our financial policy. Please read it, ask us any questions that you may have, and sign the attached signature page. A copy will be provided at your request.

- **Patient Responsibility:** We participate in many insurance plans. We suggest you become familiar with your insurance benefits and confirm our participation with your plan. Most misunderstandings about insurance can be avoided if you understand what your policy covers. Please contact your insurance company with any questions you may have regarding your coverage. Pursuant to our participation with your insurance plan we are required to collect co-pays, deductibles, and coinsurance at the time of service. These fees cannot be waved. We accept cash, checks, Debit Cards, MasterCard, Visa, American Express, and Discover.

- **Third Party Liability:** I agree that payment for services rendered is not contingent upon any settlement judgment or verdict of which they may eventually recover as a result of such liability cases. I agree to be ultimately responsible for payment in full for all services rendered in the event that a settlement is not reached or if my case is dropped by my attorney and I fail to contract with other legal counsel.

- **Proof of Insurance:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your valid driver's license and a current, valid insurance card. We may be required to collect payment in full if we are unable to verify your current insurance information. Please bring these items with you to each visit.

- **Claims submission:** If we are contracted with your insurance company, we will file your claims for you. Your insurance may require additional information from you in order to process the claim. Failure to comply with their request within 30 days will result in full patient responsibility for the claim. Please be aware that due to the length of time that is required for insurances to process payments it may be several months before you receive a statement for services.

- **Nonpayment:** Unpaid accounts will be referred to an outside collection agency and will result in dismissal from the practice.

- **Returned Checks:** There will be a $25 fee for all returned checks.

- **No shows/ Cancellation Policy:** As a courtesy to our staff and other patients we ask that you keep your scheduled appointments. If you are unable to attend a scheduled appointment, please call and cancel at least two (2) hours prior to the appointment. Failure to cancel the appointment within the time frame will result in the assessment of a fee in the amount of $15 per incidence. **A missed Saturday appointment without cancelation notice will result in the assessment of a fee in the amount of $50 per incidence.**

_____ _____

Print Patient Full Name Date

_____ _____

Patient/Guardian Signature Date

SOURCE ONE

AUTHORZATION and CONSENT AGREEMENT

Village Physical Therapy

Thank you for reviewing our Office Financial Policies and Notice of Privacy Practices. Please initial in the spaces provided below to acknowledge receipt of this information, and to enter your communication and contact preferences.

ELECTRONIC APPOINTMENT REMINDERS

You can receive an appointment reminder to your email address, your cell phone (via a text message), or your home phone (via a computer generated voice message) the day before your scheduled appointments. Where would you like to receive appointment reminders? (Check desired reminder(s) and list contact information) Please indicate if you would like Spanish Text by circling Español.

☐ Email _____ ☐ Text Message/ Español_____

☐ Voice Message _____ ☐ Spanish Voice Message _____

Appointment information is considered to be "Protected Health Information" under HIPAA. By my initials, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above.

X_____ (Initial)

☐ **I do NOT want Source One to send me electronic appointment reminders.**

PATIENT PORTAL and ELECTRONIC COMMUNICATION

Use of Electronic Communication from **SOURCE ONE/VILLAGE PHYSICAL THERAPY** to the Patient

☐ YES, I want **SOURCE ONE/VILLAGE PHYSICAL THERAPY** to communicate my information with me through a secure messaging system that is designed to keep my information safe. You will be notified by email when there is secure information for you to review.

Please enter in the space below the email address you would like to use to be notified of secure messages

_____

E-Mail Address (Please Print)

☐ NO, I do not want **Source One** to use electronic communication as a way to communicate my information to me.

RELEASE of INFORMATION

I hereby authorize **SOURCE ONE/VILLAGE PHYSICAL THERAPY**, to furnish medical records, via fax or mail, to my referring physician, insurance carrier and to the physician to whom I am referred concerning my evaluation and treatment.

X_____ (Initial)

ASSIGNMENT of BENEFITS

I authorize direct payment to be made to **SOURCE ONE/VILLAGE PHYSICAL THERAPY**, for any and all medical rendered. I hereby assign all of my right, title, and interest, to **SOURCE ONE/VILLAGE PHYSICAL THERAPY** of insurance/health and welfare benefits otherwise payable to me, not to exceed the balance due of **SOURCE ONE/VILLAGE PHYSICAL THERAPY** customary charges for the services provided.

X_____ (Initial)

CONSENT for TREATMENT

I acknowledge that the purpose of the care, reasonable alternative forms of therapy, risks of the recommended and alternative care and the risks of foregoing this care have been fully explained to and understood by me. I recognize that the practice of therapy is as much an art as a science, and therefore acknowledge that no guaranties have been or can be made regarding the likelihood of success or outcome of any therapy. I also recognize that therapy care may involve the touching of my body by Therapist or other members of the Clinic's professional staff and that full or partial disrobing may be required to facilitate such care, all of which is expressly consented to by me. I agree to cooperate fully and to participate in all therapy care procedures, to comply with the plan of care as it is established and to pay Clinic's charges for such care upon my receipt of Clinic's invoice for such care. I have read the above and I certify that I have had an opportunity to discuss the contents thereof to my satisfaction. By initialing below, I am hereby consenting to the therapy care described above, to be performed by Therapist or other members of Clinic's professional staff, as determined by Therapist from time to time.

X_____ (Initial)

HIPAA

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I can request a copy of this notice anytime. I have the right to review the notice prior to signing this consent.

I have had the opportunity to receive and review the Notice of Privacy Practices of Source One.

X_____ (Initial)

APPROVED HIPAA CONTACTS

Disclosure of Protected Health Information-Keeping information private is important to us and by default we will only disclose information related to the patient's Billing Account and Medical Conditions to the patient, referring physician, or legal guardian. The following names are people I would like to be involved in or have access to my protected health Information on a routine basis. I give permission for **SOURCE ONE/VILLAGE PHYSICAL THERAPY** to share my protected health information with:

_____	_____
Contact Name	Contact Name
_____	_____
DOB	DOB
_____	_____
Relation to Patient	Relation to Patient

CONSENT and AGREEMENT

I have carefully reviewed this document and agree to fully comply with guidelines defined herein related to the Assignment of Benefits, Financial Policy, Patient Portal Communication, HIPAA Policy and Approved HIPAA contacts. The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for health information from persons not listed on this form will require my specific authorization prior to the disclosure of any personal health information.

_____	_____
Patient Name (Please Print)	Patient Date of Birth
_____	_____
Signature of Patient, Parent, or Legal Guardian	Date

Patient Information

Name:_____

Address:_____Apt#_____

City:_____

State:_____Zip:_____

Sex: MALE FEMALE

Date of Birth:_____

Cell Phone:_____

Home Phone:_____

Work Phone:_____

Email Address:_____

Employer:_____

Employer Phone #:_____

Employer Address:_____

Social Security #:_____
(Required to file health insurance claims)

Relationship Status: Married Single Divorced Other

Emergency Contact: _____

Emergency Number:_____

Emergency Relationship:_____

WORKERS COMP:_____

Date of Injury:_____

Primary Insurance

Name:_____

Address: _____

City: _____

State: _____Zip:_____

Phone number:_____

Insured ID:_____

Group #:_____

_____
Patient Signature

_____
Guarantor Signature (If not the same as the patient)
(8/31/15)

Primary Policy Holder

☐ Same as Patient
Relationship to Patient:_____

Name:_____

Address:_____Apt#_____

City:_____

State:_____Zip:_____

Sex:_____Date of Birth:_____

Email Address:_____

Home Phone:_____

Work Phone:_____

Cell Phone:_____

Employer:_____

Social Security #:_____

Office Location (Where are you being seen today?)

☐ Fort Worth ☐ North Plano ☐ West Plano (Village PT)

How were you referred to our practice?

☐ I am an existing patient

☐ Brochure ☐ Google

☐ Employer ☐ Other Search Engine

☐ D Magazine ☐ E-Mail

☐ Direct Mail ☐ Medical Village Website

☐ Source 1 Website ☐ Insurance Website

☐ Physician Referral:_____

☐ Zoc Doc, Rate MD, Other Physician Search Tool

☐ Family/Friend:_____

☐ Other:_____

ARE YOU UNDER A LETTER OF PROTECTION (LOP) WITH AN ATTORNEY?

☐ NO

☐ YES **What Attorney?**_____

Attorney Phone #:_____

Secondary Insurance

Name:_____

Address:_____

City:_____

State:_____Zip:_____

Phone #:_____

Insured ID:_____

Group #:_____

Patient Medical History

Name: _____ **Date:** _____

Please Circle any illness or condition you have had:

ADD	Asthma	Diabetes Type I	Fracture	Low thyroid	Prostate enlargement	**Women**
Alcoholism	Back pain, chronic	Diabetes Type II	Glaucoma	Migraine	Reflux	Breast augmentation
Allergies	Cancer	Diabetes, gestational	Heart Disease	Obesity	Rheumatoid arthritis	C-section
AIDS/HIV	Constipation	Diverticular disease	Hepatitis	Osteoporosis	Seizure disorder	Hysterectomy
Anemia	Cough	Eczema	Herniated/ Slipped Disc	Osteopenia	Sleep apnea	Tubal ligation
Anxiety	Depression (current)	Endometriosis	High cholesterol	Pacemaker	Stroke	
Arthritis	Depression (past)	Fibromyalgia	High blood pressure	Postmenopausal	Other:	

Other: _____

Please list ALL Surgeries and Hospitalizations (Please indicate dates):

_____

Female Patients ONLY; Are you Pregnant: ☐ Yes ☐ No ☐ Unsure

Medications (Please include "over the counter meds" as well) _____

_____

Drug Allergies (include reaction):_____

Non-drug Allergies (include reaction):_____

Daily Functioning

Exercise	**Work Activity**	**Habits**	
None	Sitting	Smoking	Packs/Day_____
Moderate	Standing	Alcohol	Drinks/Week_____
Daily	Light Labor	Coffee/Caffeine Drinks	Cups/Day_____
Heavy	Heavy Labor	High Stress Level	Reason_____

Patient Condition

Reason for the visit: _____ When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unsure

Rate the severity of your pain on a scale from 1 (least pain) – 10 (severe pain) _____

Type of pain: Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Swelling Other_____

How often do you have this pain? _____ Is it constant or does it come and go? ☐ Constant ☐ Comes and goes

Mark an **X** on the picture below, where you continue to have pain, numbness, and or tingling.