PhysioFit

Flexion of the Body & Extension of the Mind

NAME: _____
LAST FIRST MIDDLE

ADDRESS: _____
STREET CITY STATE ZIP

PHONE: HOME: ( ) _____WORK: ( ) _____ CELL: ( ) _____

PREFERRED WAY TO CONTACT YOU: ☐ HOME ☐ CELL ☐ WORK

EMAIL ADDRESS: _____

DATE OF BIRTH: _____ **SEX:** ☐ MALE ☐ FEMALE

SOCIAL SECURITY #:_____ **MARITAL STATUS:** ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

REFERRING PHYSICIAN: _____

EMERGENCY CONTACT: NAME: _____RELATION: _____ PHONE: _____

PRIMARY INSURANCE: _____

IS THIS INSURANCE POLICY IN: ☐ YOUR NAME ☐ YOUR SPOUSES NAME ☐ OTHER
SPOUSE'S DOB: _____

SECONDARY INSURANCE: _____

ARE YOU AWARE OF YOUR INSURANCE BENEFITS? ☐ YES ☐ NO

IS THE PAIN YOU ARE EXPERIENCING A RESULT OF AN ACCIDENT? ☐ YES ☐ NO

IF YES, WHAT TYPE OF ACCIDENT?: MOTOR VEHICLE WORK RELATED OTHER

DATE OF ACCIDENT: _____

HAVE YOU HAD AN MRI OR SIMILAR TEST DONE? IF "YES", PLEASE LIST WHAT TEST AND WHERE THEY WERE PERFORMED:

TEST(S): _____ WHERE: _____

HAVE YOU HAD PHYSICAL THERAPY THIS CALENDAR YEAR? ☐ YES ☐ NO

IF YES, WHERE DID YOU HAVE THERAPY AND WAS IT FOR THE SAME REASON YOU ARE HERE TODAY? _____

HAVE YOU HAD OCCUPATIONAL OR SPEECH THERAPY THIS CALENDAR YEAR? ☐ YES ☐ NO

ARE YOU CURRENTLY RECIVEING HOME HEALTH CARE? ☐ YES ☐ NO

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Please read this form completely. By placing you initials on the appropriate line indicates you have read the sections and your signature at the bottom of the form indicates that you agree to this form in its entirety.

CONSENT FOR CARE AND TREATMENT

I, THE UNDERSIGNED, DO HEREBY AGREE AND GIVE MY CONSENT FOR PhysioFit and its employees to furnish physical therapy care and treatment considered necessary and proper in diagnosing and/or treating my physical condition.

_____ (Patient/Guardian Initials)

BENEFIT ASSIGNMENT/ RELEASE OF INFORMATION

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, or any other health/auto insurance plans to PhysioFit. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary (including photocopies of medical records) to secure payments (See HIPPA/"PHI" Form). I hereby authorize any Office/Doctor whom I have seen in the past or am currently seeing to release any and all of my medical records and/or diagnostic imaging to PhysioFit Physical Therapy.

_____ (Patient/Guardian Initials)

My signature below indicates that I have read and agree to all sections of this form. Thank you for your cooperation.

Signature of Patient/Guardian _____ Date _____

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PLEASE FILL OUT THIS FORM AS COMPLETELY AS POSSIBLE, AS IT WILL HELP BETTER ASSIST YOUR THERAPIST IN DEVELOPING A PLAN OF CARE FOR YOU. IF YOU HAVE ANY QUESTIONS PLEASE FEEL FREE TO ASK FOR ASSISTANCE. THIS INFORMATION IS CONFIDENTIAL.

Occupation: _____ **Hobbies**: _____

Date of injury/Onset of Pain: _____

Has your pain prevented you from working? YES NO If yes, how long have you been off work? _____

Work Status: At the **present time** I am able to:

_____ Work without restrictions
_____ Work the same job with restrictions
_____ Work a different job with restrictions
_____ Unable to work due to dysfunction
_____ Don't normally work outside the home
_____ Homemaker
_____ Retired
_____ Other

Have you had surgery for your current pain: YES NO

If yes, what type of surgery and when did you have it done? _____

Have you previously had physical therapy? YES NO

If yes, when and where? _____

Do you have a history of falls? YES NO

Please list all prescriptions medications you are taking (including injections and skin patches):

_____

_____

Please list all over the counter medications you are taking: _____

_____

Please list any surgeries or other conditions for which you have been hospitalized:

DATE	**SURGERIES/HOSPITALIZTION**	**REASON**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have a pacemaker? YES NO

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Are you currently having or have you experienced these symptoms in the past 3 months?

_____ Numbness _____ Pins/Needles _____ Vision Problems
_____ Hearing Loss _____ Shortness of breath _____ Skin Rash
_____ Headaches _____ Bowel/Bladder Problems

Please check all the following conditions that apply you either presently or in the past:

_____ High Blood Pressure _____ Epilepsy/Seizures _____ Gout _____ Varicose Veins
_____ Chest Pain _____ Heart Attack _____ Kidney Disease _____ Hepatitis
_____ Stroke _____ Asthma _____ Arthritis _____ Depression
_____ Heart Surgery _____ Emphysema/Bronchitis _____ Tuberculosis _____ Heart Disease
_____ Emotional/Psychological Problems _____Diabetes
_____ Cancer: Type: _____ Are you in remission? _____

How many packs of cigarettes do you smoke per day? _____

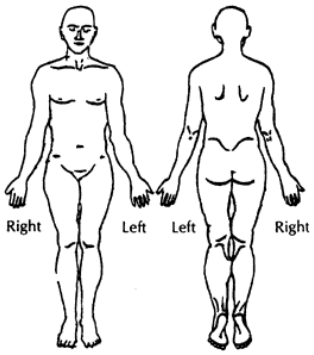
How many days of the week do you drink alcohol? _____ Average # of drinks per seating: _____

At this time, does your pain limit your ability to: (Check all that apply)

_____ Sleep _____Walk _____Exercise
_____ Perform self care tasks _____ Perform work related tasks _____ Sit for long periods
_____ Reach/Push/Pull Objects _____ Lift/Carry Objects _____ Stand for long periods
_____ Enjoy previous hobbies _____ Drive a car

PLEASE MAP YOUR AREAS OF DISCOMFORT OR ALTERED SENSATION ON THE BODY MAP.

XXX= Pain OOO= Numb/Tingling ***Weakness



How would you describe your pain? (deep, sharp, stabbing, throbbing, dull, shooting?) _____

On a scale from 1 to 10 (1 being very little pain, 10 being excruciating pain) how would you rate your current pain when it is at its:

Best: _____

Worst: _____

What is your goal for physical therapy?

_____

PhysioFit Patient Financial Policy

Patients Name: _____ Date of Birth: _____

Patient agrees to pay for all services due in full at time services are provided by our office.

Patient Financial Class Policies:

You are required to present a valid insurance card and identification card at every visit as needed throughout your care.

Commercial Insurance Carriers: We bill most insurance carriers for you if proper paperwork is provided to us. Any outstanding balances, co-payments and deductibles are due prior to checking in for your appointments. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated. If your insurance company requires preauthorization for physical therapy services it is your responsibility to get preauthorization before treatments begin. If an insurance carrier has not paid within 60 days of billing, fees are due and payable in full from you. Please note that at this time, PhysioFit is considered "out of network" with Blue Cross/ Blue Shield and United Healthcare ,which means that you will be responsible for your out of network copayment and deductible which are usually higher than your in network responsibilities.

Medicare: Our office is a Medicare participating provider and we will bill Medicare for you. We will also bill your secondary insurance for you. Any balance not paid by Medicare and your secondary insurance will be your responsibility. Medicare allows $1,880.00 per calendar year for outpatient physical therapy and speech language therapy combined. Outpatient therapy settings include: private practices, skilled nursing facilities (SNF's), home health agencies, outpatient rehabilitation facilities, comprehensive outpatient rehabilitation facilities, hospital outpatient departments. If your therapy services go over the $1,880.00 therapy cap, your therapist or doctor can ask for an exception, should they determine that the services continue to be medically necessary. Even if your therapist or doctor asks for an exception, this is not a guarantee that you will not have to pay for costs above the $1,880.00 therapy cap amounts. If Medicare decides, at any time (even after your therapy services have been paid for), that your therapist or doctor did not show enough proof that your therapy services were medically necessary, you may have to pay for the total cost of the services above the $1,880 therapy cap amount.

Worker's Compensation: If your visit is work- related we will need the case number and carrier name prior to your visit in order To correctly bill your workers compensation insurance carrier.

Auto-Mobile Accidents: If your visit is auto-accident related we will need the case number and carrier name prior to your visit in order to bill the car insurance company. If at any time during your visits at PhysioFit you exceed your physical therapy limit set by the car insurance carrier you will be responsible for the remaining balance. At this time, we can bill your primary health insurance if you would like, but if they do not pay, the balance will be the patient's responsibility. Our office does not accept Letters of Protection for any services that are rendered once your PIP benefits have been exhausted, these services must be paid at time of visit.

Methods of payment:
Our office accepts the following payment methods:
Cash, Personal Check, Credit Cards and Patient Financing options for those patients who are credit worthy.

For **returned checks**, we assess a $25.00 NSF charge, and report to the local district attorney's office checks that are not paid within 2 weeks of being returned to our office.

If not paid according to terms the patient understands that our office reports to an outside collection agency. In the event that your account is turned over for collections, patient agrees to pay all additional fees accessed in the collection of debt. These fees include collection agency fees and attorney fees.

The patient is ultimately responsible for all fees for services. I have read, understand and agreed to the above financial policy for payments of professional fees.

Patient Name: _____ Date: _____

Patient Signature: _____ Date: _____

Acknowledgement of Reciept of Notice of Privacy Practices

As part of my health care, PhysioFit (The Company) creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves and a basis for my continuing care. I understand that this information is used as a means of communicating among The Company's personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnosis and surgical information to my bill. I understand that this information is a way for third party insurance companies to assure that a service we bill for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for The Company that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that The Company may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that The Company is not required to agree to the restrictions requested. The procedure to request restrictions on information use and disclosure is contained in the Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of PhysioFit and agree to the liability limitations explained therein.

_____ _____ _____

Signature of Patient or legal representative | Date | Relationship to the Patient

_____

Printed Name of Patient