TRI-STATE
SPECIALISTS

ORTHOPAEDIC SURGERY
DERMATOLOGY
GENERAL SURGERY
PLASTIC SURGERY

Main Office
2730 Pierce Street - Suite 300 • Sioux City, IA 51104
Phone (712) 224-8677 • Fax (712) 277-1662

Physical Therapy
2730 Pierce Street - Suite 203 • Sioux City, IA 51104
Phone (712) 224-8677 • Fax (712) 277-1662

MRI Services
2730 Pierce Street - Suite B11 • Sioux City, IA 51104
Phone (712) 224-8677 • Fax (712) 277-1662

PATIENT WAIVER FORM

Provider name:

Tri-State Specialists, LLP
2730 Pierce St, Suite 300
Sioux City, IA 51104

Patient name:_____DOB:_____

The services or supplies provided may not be covered by your insurance plan. If you would still like for us to provide you with the service or supply, please sign below.

I understand that my insurance may not pay for the services or supplies provided and I agree to pay for such services or supplies.

Patient signature_____**Date:**_____

TRI-STATE SPECIALISTS

ORTHOPAEDIC SURGERY
DERMATOLOGY
GENERAL SURGERY
PLASTIC SURGERY

Main Office
2730 Pierce Street - Suite 300 • Sioux City, IA 51104
Phone (712) 224-8677 • Fax (712) 277-1662

Physical Therapy
2730 Pierce Street - Suite 203 • Sioux City, IA 51104
Phone (712) 224-8677 • Fax (712) 277-1662

MRI Services
2730 Pierce Street - Suite B11 • Sioux City, IA 51104
Phone (712) 224-8677 • Fax (712) 277-1662

CONSENT FOR CARE, TREATMENT, MEDICAL RECORD RELEASE, AND ASSIGNMENT OF BENEFITS

I, the undersigned, do hereby agree and give my consent for **Tri-State Specialists, LLP Physical Therapy** to furnish medical care and treatment to _____ considered necessary and
(Patient Name)
proper in diagnosing and/or treating their physical and mental condition. I also understand that my medical records will be released to my *referring physician* for the continuity of my care. If I want my medical records to be released to another physician or entity, then I will need to sign an additional release stating to whom these records need to be released. I also understand that **Tri-State Specialists, LLP Physical Therapy** may charge a fee for the copying and mailing of these records.

By my signature, I hereby assign all my medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plans to **Tri-State Specialists, LLP Physical Therapy.** 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 medical records, to secure payment. I understand that I am responsible for the entire bill when services are rendered and that **Tri-State Specialists, LLP Physical Therapy** will bill my insurance carrier as a courtesy. I also understand that I must pay my co-pay and/or coinsurance at the time of service. If any payment is subsequently made by you or your insurance carrier in excess of the balance due, **Tri-State Specialists, LLP Physical Therapy** will promptly refund the credit. In addition, I understand that if I receive any direct payment from my insurance carrier I have the obligation to promptly remit the same to **Tri-State Specialists, LLP Physical Therapy.**

I understand and agree that if I fail to make any of the payments for which I am responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by **Tri-State Specialists, LLP Physical Therapy,** I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees. A fee of 1.5 % will be added to your account for each billing period past 60 days. Also, a fee of $25.00 for a returned check will be added to your account for any checks returned by the bank.

NOTE: Estimated coverage information is provided as a courtesy to our patients but is not intended to release them from the total responsibility for their account balance.

The above does not apply to those patients who are considered Worker's Compensation. However, be advised that as a Compensation patient, you may be held responsible for your charges in the event that your claim is denied.

Tri-State Specialists, LLP Physical Therapy will do their best to work with your insurance carrier to receive payment.

I have read and understand the above. I have also received a copy of the collection process and understand that I am responsible for the payment of my account.

_____ _____
Patient or Responsible Party Signature Date

_____ _____
Staff Member Signature Date

TRI-STATE SPECIALISTS

Physical Therapy Attendance Policy

(Please read thoroughly)

Tri-State Specialist, LLP Physical therapy strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient in order to minimize your waiting and assure continuity of your treatment. Your consistent attendance of the planned treatment regimen is paramount to your full recovery. While we are sensitive to the fact that an emergency may occur in a rare instance, cancellations, especially last minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of the other patients. We must ask for your full cooperation with the following policy:

- If you are more than 15 minutes late for your appointment and fail to notify us, treatment may be cancelled.
- A scheduled appointment MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE!
- Failure to show up for an appointment without notifying us will result in ("NO SHOW") for that appointment. Furthermore, 2 consecutive no-shows OR 3 total no-shows will result in the cancellation of all remaining scheduled appointments.
- All cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payer.
- Repeated failure to comply with this ATTENDANCE POLICY will result in your name being placed on a "Schedule Based on Availability" list. This will require you to call for an open appointment on each day you would like to receive therapy. We will do everything possible to accommodate you, as space on the schedule permits.

We believe that this policy is necessary for the benefit of all our patients, so that we may continue to provide high quality treatment and service to everyone. All of the staff at Tri-State Specialist, LLP appreciates your anticipated adherence and cooperation with this policy. We wish you the best of luck with your treatment. We are here to help you attain all of your goals and optimize your return to all of your pre-injury activities.

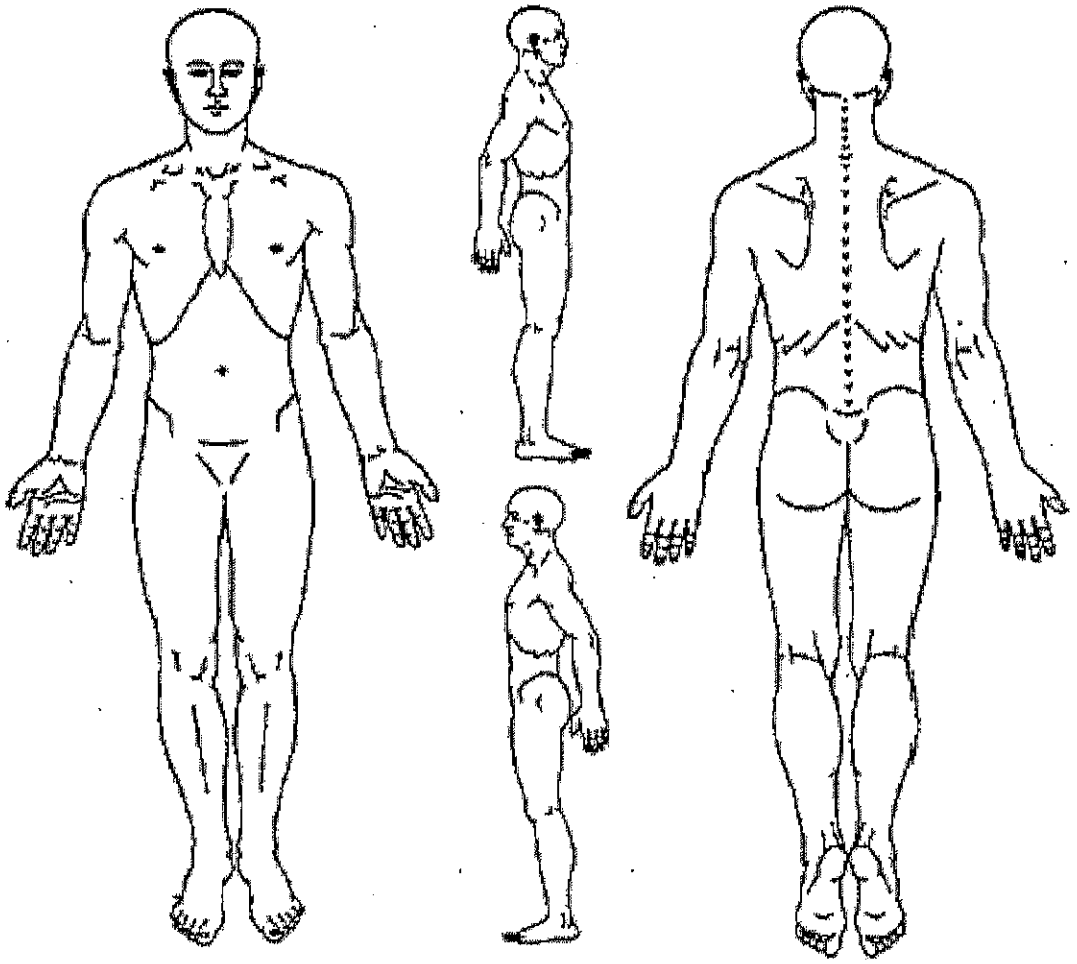
Patient Signature _____ Date: _____

Name:_____ Date:_____

PAIN DIAGRAM

On the diagrams below mark where you are experiencing pain, right now. Use the letters below to indicate the type and location of your sensations.

Key: A – ACHE B – BURNING N – NUMBNESS
P – PINS & NEEDLES S – STABBING O - OTHER



PAIN SCALE

Rate the severity of your pain by checking one box on the following scale.

No Pain — Worst Possible Pain

0	1	2	3	4	5	6	7	8	9	10

Patient's Signature: _____ Date: _____