LAFAYETTE
PHYSICAL THERAPY INC

BAY AREA
PHYSICAL THERAPY

3468 Mt. Diablo Blvd., Suite B110
Lafayette, CA 94549
(925) 284-6150

Welcome to Lafayette Physical Therapy and Bay Area Physical Therapy!

We wanted to take the time to thank you for choosing us as your partner to wellness and rehabilitation. Our goal is to restore movement and improve function through the individualized care with our staff of professional, highly trained and educated physical therapists. Please do not hesitate to call our Front Desk with any questions or concerns at the appropriate location.

Information for your first visit:

Please review and complete the attached paperwork and bring it with you to your first visit. The paperwork attached is for clients with **PRIVATE** insurance (E.g. Blue Cross, Blue Shield, Aetna, etc.) as their primary insurance for this case. Please print it single-sided for proper clinical distribution. If you have a different primary insurance for this case please contact our front desk for new forms or download the correct forms from our website.

Please arrive early for your first appointment. If you choose to complete your paperwork in the office on the day of your appointment we recommend coming in 20-30 minutes before your scheduled appointment time. If you bring this packet completed we recommend coming in 5-10 min before your scheduled appointment time in order to check you in, go over your benefits and give you the most time to work with your Physical Therapist.

What to Bring

- A referral form signed by your physician (if applicable).
- Any test results, MRI reports, or X-ray reports relevant to the condition for which you are seeking care for.
- Medications List
- Proof of your insurance, such as an insurance card.
- Photo identification, such as your driver's license.
- Method of payment (if applicable) for deductibles, copayments, co-insurances, etc.
- For minors – please have a Parent or Guardian complete the paperwork and attend the first visit for patients under the age of 18 years.

What to Wear

Please arrive in comfortable clothing and shoes that allow for your full range of motion as well as accessibility for your therapist to work on the affected area.

Evaluation
Your first visit with us will be an opportunity for your physical therapist to assess your specific condition, needs, and to create a plan of care. The evaluation appointment is scheduled for 60 min, however, please allow up to an hour and 15 min for the full process.

Your physical therapist will:

- Perform an evaluation by reviewing your medical history, discussing your condition with you, carrying out tests and measures (such as Range of Motion and Strength testing), and making clinical judgments based on the data gathered during this examination.
- Develop an individualized treatment plan based on the evaluation and will make adjustments as needed throughout your course of care.
- Communicate with you on your condition, treatment plan, functional goals and progress.
- Provide information and education to you, your family or caregivers (if present) about your treatment plan, prevention, and individualized home programs to maintain function achieved during physical therapy.
- Work in partnership with your referring physician to maintain synergistic care.

Subsequent Visits
Please allot 45 to 60 minutes for all subsequent visits. During your visit, you will be attended to by your physical therapist and our exceptionally educated and trained physical therapy aide staff.

To schedule an appointment please stop by our front desk or call them at the appropriate front desk number for assistance.

We recommend scheduling your subsequent visits several weeks in advance in order to book appointments on your preferred days and times. We usually schedule our patients with one primary therapist and provide a recommended alternate therapist in the event that your primary therapist is not available or a particular day or time is no longer conducive to your schedule.

We encourage consistency in your attendance as it can be a major key to your recovery. Please review the "Late cancellations & No Show policy", as well as our other important policies and procedures attached for specific information on our agreements with our patients.

Throughout Your Care
Communication throughout your care is very important. If you have questions about your condition, progress, goals, or any other part of your care please discuss them with your therapist. If you have questions about your insurance, benefits, authorization, billing statements, or any other items please ask to speak to our administrative team right away. You will be asked to fill out several surveys throughout your care which help your therapist assess your initial condition and progress. It is extremely important that you complete these surveys and answer as honestly as possible. Our goals is to provide the best possible care and experience for you.

Thank you and we look forward to working with you towards recovery!

Rev. 2019

LAFAYETTE PHYSICAL THERAPY, INC.

Patient Information

Last Name (Legal Names Please)		First Name	MI	Sex	Marital Status
Home Phone	Alternative Phone	SSN	DOB		AGE
Address		City	State		Zip
Employer		Occupation	Work Phone		
Employer Address		City	State		Zip
Insurance Subscriber Name		Ins. Subscriber Employer	**DOB**		Phone
Emergency Contact Person*		Relation	Phone		*For emergencies and urgent info if we are unable to get ahold of you.
Referring Doctor		Have you received any outpatient rehabilitation therapy this year? ☐ Yes:_____ # visits ☐ No			

Automated Appt. Reminders: **Please select a phone number &/or e-mail to receive appointment reminder notifications on**

☐ Home ☐ Cell ☐ Text ☐ Email: _____ ☐ No reminder

Would you like to receive our e-mail newsletter? Yes - e-mail: _____ ☐ No

Can we send a welcome email and quality assurance checks? Yes – e-mail: _____ ☐ No

Do you currently have any open claims? i.e. worker's comp, motor vehicle accident, injury, etc. ☐ No ☐ Yes

☐ Explain: _____

FOR OFFICE USE ONLY:
Our front desk will fill out this portion upon your arrival

Insurance: The following benefits were quoted to us by your insurance company. This is not a guarantee of payment by your insurance. You are responsible for knowing your benefits.

_____ ☐ Patient is eligible for benefits: Effective Date: _____ to _____ ☐ Month to month Plan

☐ Coverage is based on medical necessity ☐ Rx required ☐ Requires Prior Authorization

Physical Therapy Benefits Information:

$_____ Total deductible, $_____ deductible met, collect $_____ per visit toward deductible*

Insurance pays _____ %, patient responsibility is _____ co-pay / co-insurance. We will collect $_____ **per visit***

☐ Your initial visit includes both evaluation & treatment which can have a higher share of cost. We will collect $_____for the initial visit*

***Patient financial responsibility may be MORE than the amount collected at each visit to go toward your deductible or co-insurance. The cost of each visit is based on the services you receive on a given day.** You will receive a bill for any remaining balances once your insurance processes your claims.

Patient/Guardian Initials: _____

$_____ Max $ per year, $_____remaining

$_____ Out of pocket, $_____ out of pocket met. Once met, insurance will cover at 100%

_____ Max visits per year, _____ visits used, _____ remaining, combined with: _____

_____ Other/Secondary Info: _____

I certify that the information provided is true and accurate. I authorize Lafayette Physical Therapy, Inc (herein referred to as LPT) to bill my insurance carrier, and instruct my insurer to pay any benefits directly to LPT. I understand that any charges not covered by my insurance will be my responsibility. I agree to pay LPT any amount due after my insurance company has paid or made a decision on my claims. **Should my insurance pay me directly, I agree to forward the payment to LPT.** I have read and understand the above information. A photocopy of this agreement shall be as valid as the original.

_____ _____ Office Use: _____

Patient/Guarantor Signature Date Interviewer Initials

LAFAYETTE PHYSICAL THERAPY INC

Patient Policies and Agreements

Thank you for choosing Lafayette Physical Therapy for your physical therapy needs. We look forward to a rewarding relationship with you throughout your plan of care. The policies below are important to our relationship and assist us in providing you with the best quality care. Please let our staff know if you have any questions. These policies will also include care at Bay Area Physical Therapy, our sister company.

_____ Initial

1. **Copayments, Deductibles and Co-Insurances: are due at the time of service**. Lafayette Physical Therapy, Inc. (herein referred to as "LPT"), asks that you pay a reasonable amount towards your deductible and/or coinsurance each visit. This collected amount typically does not cover your total share of cost. The front desk will inform you of your balance and you will receive a monthly statement when deductible and co-insurance balances are updated.

_____ Initial

2. **Account Responsibilities:** It is your responsibility to know your insurance coverage including deductibles, co-payments, visit limits, etc. Please verify your coverage with your insurance company. As a courtesy to you we will verify and bill your insurance carrier, however, you are ultimately responsible for the payment of your bill. You are responsible for any account balances not covered under your insurance, including deductibles and co-insurance amounts based on your insurance contract. Please be advised that a quote of eligibility and benefits is not a guarantee of payment. All benefits are subject to the eligibility, medical necessity, and the terms, conditions, limitations and exclusions of your individual health benefit plan at the time that the services are rendered. In the event that your insurance refuses to pay or does not pay within 90 days, you will be responsible for your balance in full. Many insurance companies have additional conditions that may affect your coverage. If your insurance carrier denies any part of your claim, or if you elect to continue therapy past the approved period, you will be responsible for your account balance.

3. **Late Policy:** Please be on time for your appointments. A professional staff member has been scheduled to treat you specifically. If you are late by 10 minutes or more you may be required to reschedule or wait for the next available appointment. If you are unable to be seen due to tardiness you will be charged the no show fee below. If you are running late please call our office as soon as possible so we can attempt to accommodate you at a later time.

_____ Initial

4. **No Show & Cancellation Policy:** Our professional staffing is planned to accommodate scheduled visits. There is a $75.00 charge for no show or same day cancellations. Please provide 24 hour notice for appointment cancellation. LPT may discharge patients who fail to attend their scheduled appointments. This cannot be billed to your insurance company. Worker's Compensation patients cannot be charged for missed visits, however, we are required to report them to your case manager which may affect your claim, and you may be required to schedule same day appointments only.

_____ Initial

5. **Overdue Accounts & Fees:** Payment is due upon receipt of a statement or being notified by the front desk. Accounts 30 days or more overdue may be assessed a re-billing fee of $5 for every additional statement sent. Accounts over 60 days overdue may be assessed a late fee of $25 and assigned to a collections agency (currently Transworld Collection Agency). A $25.00 fee will apply to any returned checks.

6. **Financial Hardship:** If you are experiencing difficulties and are unable to afford the cost of your therapy services please inform the front desk and our office will go over your options with you. Please let our office know immediately.

7. **Insurance Changes:** It is your responsibility to notify our office of any changes to your insurance. In the event that you do not inform us of an insurance change and your insurance does not pay you will be responsible for the unpaid balance.

8. **Insurance Ownership:** I guarantee that the insurance and personal information I provided is true and correct and this is NOT a third party (someone else's) insurance, and that I am a direct beneficiary (self, spouse, or child) of the policy holder.

Continued on back

Patient Policies and Agreements Continued

9. **Cell Phones and Distractions:** As a courtesy to other patients and our staff please silence your cell phone while you are in our office. Please do not allow your phone to detract from your treatment. If you are unable to attend your full treatment due to urgent phone conversations you may be asked to re-schedule. A missed appointment fee may apply.

10. **Children Requiring Supervision:** Please do not bring children to your appointments that require supervision. Your full attention is required for your full treatment. You may bring children who are capable of waiting for you in the waiting room unattended. We appreciate your understanding.

11. **Informed Consent:** I understand the expected benefit of physical therapy and I understand that I can refuse any procedure prior to its performance. I hereby consent to the procedures which may be performed while I am a patient of LPT under the direction of a Licensed Physical Therapist. This may include but not limited to: examination/evaluation, physical testing, application of modalities such as hot/cold pack, electrical stimulation, ultrasound, etc, application of therapeutic procedures intended to improve function including therapeutic exercises, neuromuscular rehabilitation, gait training, manual or mechanical traction, soft tissue mobilization, joint mobilization, and any other procedure under the scope of physical therapy practice. I give consent to and release Lafayette Physical Therapy, Inc. from liability arising from providing CPR, AED and any other emergency medical assistance in the event of an emergency.

12. **Important Notice from the Federal Government:** "It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments…even if your medical office allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under the Federal Standards, you may not routinely evade paying your responsibility portions for medical care as outlined in your insurance plan… " [Federal Register, December 19, 1994, the Office of Inspector General (OIG).] Contact the Office of the Inspector General, Department of Health and Human Services for more information: (202) 619-1343, paffairs@oig.hhs.gov.

13. **Privacy Acknowledgement:** I understand that I have the right to review LPT's notice of privacy practices prior to signing this document. The full notice is posted in the waiting room and I have read and understand the notice. The notice of privacy practices describes the types of uses and disclosures of my protected health information and is summarized below. I further acknowledge that I have the right to request a copy of the notice.

    Consent to Use and Disclose Health Information: I also understand that when necessary, LPT or anyone affiliated with our organization may contact me at any phone number provided. Your verbal communication and clinical records are strictly confidential. The following are the ways that we use your information and communications: (1) Treatment: information shared with our staff to provide quality treatment and billing, (2) Payment: information on your diagnosis, dates, treatment, etc. shared with your insurance company to process your claims, (3) Internal Administrative Activities: including quality control audits, software updates, etc, (4) Appointment Reminders: may be provided to a phone number or e-mail of your choosing. You may discontinue reminder calls or emails at any time by contacting our office in writing. (5) When required by Law, (6) To inform you of treatment alternatives or update you on relevant products or services offered, (7) Emergencies, (8) When you sign a release to have information shared.

14. **Permission to Treat a Minor**: I consent to _____ being treated as a patient by LPT. I understand that at times it may be necessary to schedule appointments during school hours and that it is my responsibility to ensure he/she is on time for his/her treatment.

    _____ _____ _____
    Parent or Legal Guardian Name Signature Date

Thank you for your cooperation.

Please sign and date below indicating that you have read and understand the above policies & agreements.

_____ _____ _____
Patient Name (Or Parent/Guardian if under 18) Signature Date

LAFAYETTE PHYSICAL THERAPY, INC.

Medical History and Pain Questionnaire

Name: _____ **Date:** _____ **Age:** _____

1) Have you ever had **any** of the following **problems** or **conditions**?

Now	Past	Never		Now	Past	Never		Now	Past	Never	
			Heart/Vascular Disease								
☐	☐	☐	Congestive Heart Failure (CHF)	☐	☐	☐	Angioplasty	☐	☐	☐	High Cholesterol
☐	☐	☐	Heart Attack	☐	☐	☐	Stents	☐	☐	☐	Vascular Disease
☐	☐	☐	Coronary Artery Bypass Graft (CABG)	☐	☐	☐	Arrhythmia	☐	☐	☐	Atherosclerotic Disease (CAD)
☐	☐	☐	Acquired Respiratory Distress Syndrome	☐	☐	☐	Stroke/TIA	☐	☐	☐	Angina
☐	☐	☐	Hypertension/High Blood Pressure (with or without medication)	☐	☐	☐	Pacemaker	☐	☐	☐	Peripheral Artery Disease
			Lung Disease								
☐	☐	☐	Chronic obstructive pulmonary disease (COPD)	☐	☐	☐	Asthma	☐	☐	☐	Emphysema
☐	☐	☐	Chronic Bronchitis	☐	☐	☐	Pneumonia	☐	☐	☐	Tuberculosis
			General Medical Conditions								
☐	☐	☐	Arthritis (rheumatoid/ osteoarthritis)	☐	☐	☐	Broken Bones	☐	☐	☐	Osteoporosis
☐	☐	☐	Gastro Intestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)	☐	☐	☐	Incontinence	☐	☐	☐	Kidney, bladder, prostate, urination problems
☐	☐	☐	Neurologic Disorders - MS, Parkinsons, etc.	☐	☐	☐	Dizziness/ Nausea	☐	☐	☐	Metal pins/plates post fracture
☐	☐	☐	Visual Impairment - cataracts, glaucoma, macular degeneration	☐	☐	☐	Hepatitis, HIV, or AIDS	☐	☐	☐	MRSA/Staph infections/other infections (Specify)
☐	☐	☐	Back Pain (neck pain, low back pain, degenerative disk disease, spinal stenosis, etc.)	☐	☐	☐	Prosthesis/ Implants	☐	☐	☐	Hearing Impairment: very hard of hearing, even w/hearing aids
☐	☐	☐	Sleep Dysfunction	☐	☐	☐	Depression	☐	☐	☐	Allergies (Specify)
☐	☐	☐	Numbness or Tingling	☐	☐	☐	Headaches	☐	☐	☐	Pregnancy
☐	☐	☐	Anxiety/ Panic Disorders	☐	☐	☐	Cancer	☐	☐	☐	Seizures/Epilepsy
☐	☐	☐	Diabetes	☐	☐	☐	Sensitivity to heat/ice				

If **YES** to any of the above, please explain:

_____

_____

_____

Other:

_____

PLEASE FILL OUT BACK PAGE

2) Have you ever had **Physical Therapy** treatment before? ☐ Yes ☐ No

If yes, when and what was it for? _____

3) Have you ever taken **steroids** (**ie: asthma inhalers)** for an extended period of time? ☐ Yes ☐ No

4) Have you ever taken **anti-coagulants (ie: Aspirin)** for an extended period of time? ☐ Yes ☐ No

5) Do you **smoke**? ☐ Yes ☐ No If yes, how much and how often? _____

6) Have you had an **unusual weight loss or gain** recently? ☐ Yes ☐ No

7) Please list ALL **surgical procedures** you have had in the past and give the dates if possible:

_____

_____

8) Please list **recent diagnostic studies (X-Ray, MRI, CAT, etc.)** and give dates if possible:

_____

9) If taking any medications please check this box and complete attached medication list: ☐

10) Briefly describe the **history of your present injury, accident, or illness**: **Date of Injury:** _____

_____

_____

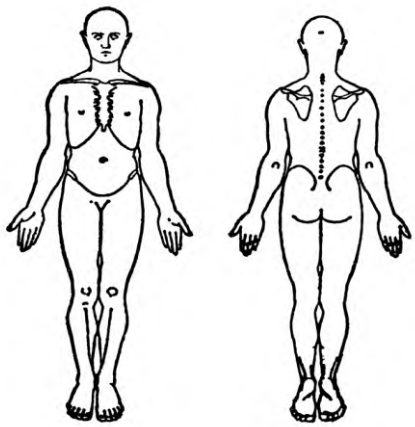
11) Do you have any pain with your condition? ☐ Yes ☐ No [If "Yes", please answer 11a-c]

a) What **aggravates** your pain?

☐ Bending ☐ Twisting ☐ Reaching
☐ Sitting ☐ Standing ☐ Walking
☐ Driving ☐ Other: _____

b) What **eases** your pain?

☐ Stretching ☐ Standing ☐ Changing Positions
☐ Lying Down ☐ Cold ☐ No Movement
☐ Walking ☐ Heat ☐ Massage
☐ Sitting ☐ Other: _____



c) For the **<u>current</u>** condition, on a scale of **0 to 10**
Visual Analog Scale: 0 Being no pain, and 10 being worst pain ever.
What is your: Pain level **today**: _____ Pain at its **best**: _____ Pain at its **worst**: _____

12) Please **indicate and describe** on the body chart the **area of your problem(s) and/or your discomfort**.

13) Have you **fallen** in the past year? ☐ Yes, ____ times. ☐ No
If Yes, Did you sustain any **injuries** from the fall(s)? ☐ Yes ☐ No

Please explain the circumstances surrounding the fall(s) that you are reporting above, including injuries:

_____

_____ _____ PT Initials: _____

Patient Signature **Date** PT Reviewed & Discussed PMH with Patient

LAFAYETTE PHYSICAL THERAPY, INC.

Health History Addendum
Medications and Supplement List

_____ _____
Patient Name Date

Prescription Medications - Please list all prescription medications you are currently taking:

Name	Dosage (mg)	Frequency	Route (e.g. oral, injection, etc)

Over-the-counter Medications - Please list all over-the-counter medications you are currently taking:

Name	Dosage (mg)	Frequency	Route (e.g. oral, injection, etc)

Herbals, Vitamins, Minerals, Nutritional Supplements - Please list all supplements you are currently taking:

Name	Dosage (mg)	Frequency	Route (e.g. oral, injection, etc)

PT reviewed with patient (Initials): _____

Consent for Communication via E-mail

I, _____, hereby consent to have Lafayette Physical Therapy, Inc. (Includes Bay Area Physical Therapy) communicate with me, where appropriate via e-mailing regarding the following aspects of my medical care and treatment: [prescriptions, appointments, billing, home exercise program, etc.]. I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mail communications between my Lafayette Physical Therapy, Inc. and me, or between Lafayette Physical Therapy, Inc. and referring physicians, other medical professionals, adjusters, and case managers regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail communications between Lafayette Physical Therapy, Inc. and me or between Lafayette Physical Therapy, Inc. and referring physicians, other medical professionals, adjusters, and case managers regarding my medical care and treatment may be printed out and made a part of my medical record.

I understand that in an urgent or emergent situation I should call my provider or go to the Emergency Room and not rely on email.

I understand that the company email is not monitored for cancellations or appointment scheduling. Please call in to the front desk for any schedule changes.

Email address: _____
(Please print legibly)

Signature _____ Date _____

OR

I, _____, decline to receive communication from Lafayette Physical Therapy, Inc. via email.

Signature _____ Date _____