CLEMENTS PHYSICAL THERAPY

PLEASE PRINT TODAY'S DATE:

PATIENT INFORMATION

LAST NAME_____ FIRST_____ MI_____ AGE_____

ADDRESS_____ APT___ CITY_____ STATE____ ZIP_____

E-MAIL_____ HOME PH_____ CELL PH_____

OCCUPATION_____ EMPLOYER/SCHOOL_____ WORK PH_____

SOCIAL SECURITY NO_____ SEX: M / F DATE OF BIRTH_____ MARITAL STATUS: S / M / D / W

EMERGENCY CONTACT (Name)_____ PHONE_____ RELATIONSHIP_____

INSURANCE INFORMATION

RESPONSIBLE PARTY (If under 19 years)_____ PH_____

ADDRESS_____ APT___ CITY_____ STATE____ ZIP_____

PRIMARY INSURANCE COVERAGE
INSURANCE COMPANY_____ PH_____

SUBSCRIBER NAME_____ SS# _____ DATE OF BIRTH_____

RELATIONSHIP TO PATIENT_____ POLICY ID#_____ GROUP #_____

SECONDARY INSURANCE COVERAGE
INSURANCE COMPANY_____ PH_____

SUBSCRIBER NAME_____ SS# _____ DATE OF BIRTH_____

RELATIONSHIP TO PATIENT_____ POLICY ID#_____ GROUP #_____

Assignment of authorization for treatment, insurance benefits, release of information, medical release and responsibility for payment:

I authorize Clements Physical Therapy to provide physical therapy treatment, tests and procedures considered advisable by my physician.
I authorize Clements Physical Therapy to bill my insurance directly and I authorize payment of benefits directly to Clements Physical Therapy.
I understand that I am ultimately responsible for my physical therapy charges, and I agree to pay my deductible, my co-insurance or co-payment, and any charges not reimbursed by my insurance carrier.

I authorize Clements Physical Therapy to release medical information acquired in the course of my treatment and examination to my insurance company and to my physicians.

If for any reason the account should become delinquent, I agree to pay all rebilling charges, costs related to collection efforts, and reasonable legal fees. I have read and understand the policies as mentioned above.

_____

SIGNATURE OF PATIENT, GUARDIAN OR AUTHORIZED REPRESENTATIVE DATE SIGNED

CURRENT INJURY / DISORDER INFORMATION

-REFERRING DOCTOR:_____TYPE OF INJURY/DISORDER _____

-IS THIS INJURY RELATED TO: WORK / AUTO / SPORTS / FALL/ OTHER _____

-PLEASE DESCRIBE HOW AND WHEN INJURY/DISORDER OCCURRED_____

-PLEASE ANSWER THE FOLLOWING QUESTIONS REGARDING YOUR PAIN/SYMPTOMS:

MY PAIN IS WORSE IN THE: MORNING / EVENING / SAME / FLUCTUATES / CONSTANT

PLEASE LIST ANY ACTIVITIES THAT INCREASE YOUR PAIN/SYMPTOMS:

PLEASE LIST ANY ACTIVITIES THAT DECREASE YOUR PAIN/SYMPTOMS?

WHAT IS YOUR LEVEL OF PAIN RIGHT NOW? PLEASE CIRLCE BELOW

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST PAIN EVER

HAVE YOU RECEIVED HOME HEALTH CARE WITHIN PAST 60 DAYS?

YES/NO IF YES, DATE YOU WERE DISCHARGED? _____COMPANY NAME? _____

HAVE YOU RECEIVED PT, OT, OR SPEECH THERAPY WITHIN THE CALENDAR YEAR? YES/NO

If yes, please explain _____Inpatient or Outpatient

HOW DID YOU HEAR ABOUT CLEMENTS PT?

_____Physician _____Web site/Advertisement _____Friend/Family/Co-worker _____Insurance company

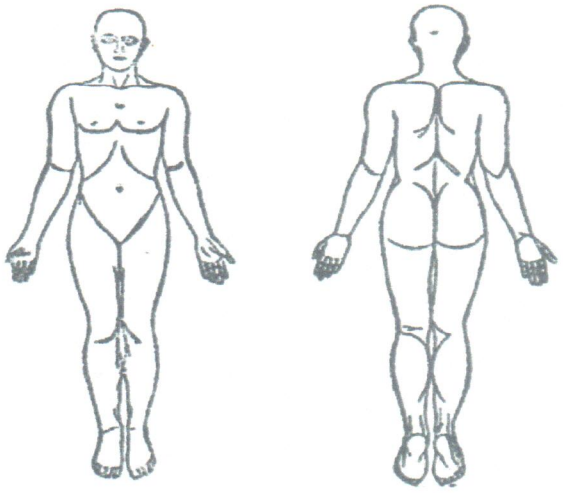
_____Coach/ Athletic Trainer ___Other _____ Who may we thank for referring you?_____

Describe your pain. Use all that apply.

- Sharp
- Dull
- Tingling
- Tight
- Shooting
- Throbbing
- Numb
- Pulling
- Burning
- Ache
- Heavy
- Stabbing

Describe the behavior of your symptoms. Use all thatapply.

- Constant (Never goes away)
- Intermittent (relieved with some positions or rest)
- Occasionally (Daily or less frequent)
- Infrequently (once a weekor month)
- Previously (No longer present)
- Variable (Sometimes worse than other times)



CIRCLE AREA OF PAIN ON THE DIAGRAM

Patient Signature _____ Date _____

MEDICAL HISTORY SCREENING FORM

To best serve your needs and understand your medical condition – please complete the following.

Please circle yes or no and list where appropriate:

Have you or any immediate family member ever been told you have or are you aware of symptoms related to	**Patient**		**Family**	
Cancer?	Yes	No	Yes	No
Diabetes?	Yes	No	Yes	No
High blood pressure?	Yes	No	Yes	No
Heart disease/Heart attack?	Yes	No	Yes	No
Angina/Chest pain?	Yes	No	Yes	No
Stroke?	Yes	No	Yes	No
Osteoporosis or Osteopenia?	Yes	No	Yes	No
Osteoarthritis?	Yes	No	Yes	No
Rheumatoid arthritis?	Yes	No	Yes	No
Other?_____	Yes	No	Yes	No

Do you have a history of:						
Allergies/Asthma?	Yes	No	Are you under stress?	Yes	No	
Headaches?	Yes	No	Are your symptoms getting	Worse	The same	Improve
Bronchitis?	Yes	No	How are you able to sleep?	Fine	Moderate	Medicate
Kidney disease/problems?	Yes	No	Do you have a problem with	Vision	Hearing	Speech
Rheumatic fever?	Yes	No	How do you learn best?	Seeing	Doing	Hearing
Ulcers?	Yes	No	Do you drink alcohol?	Yes ____/week		No
Sexually transmitted disease?	Yes	No	Do you or have you smoked?	Yes _Packs/Day __Yrs		No
Seizures?	Yes	No	Describe your activity level	Minimal	Moderate	High
Nervous disorders? _____	Yes	No	Date of last medical examination	_____/_____/_____		
Hernia?	Yes	No	**List of Medications you currently use:**			
Metal implants?	Yes	No				
Pacemaker?	Yes	No				
Dizziness/Balance problems?	Yes	No				
Are you pregnant?	Yes	No				
Sensitive to heat/ice?	Yes	No				
Are you depressed?	Yes	No				

In the past 3 months, have you had or did you experience:		
A change in your health?	Yes	No
Nausea/vomiting?	Yes	No
Fever/chills/sweats?	Yes	No
Unexplained weight change?	Yes	No
Numbness or tingling?	Yes	No
Changes in appetite?	Yes	No
Difficulty swallowing?	Yes	No
Changes in bowel or bladder dysfunction?	Yes	No
Shortness of breath?	Yes	No
Dizziness?	Yes	No
Upper respiratory infection?	Yes	No
Urinary tract infection?	Yes	No

Patient Signature: _____

Date of Completion: _____

Welcome to Clements Physical Therapy!

Please take a minute to review our financial policies, which are designed to clarify your billing payment questions and assist us in serving you.

- In order to assist you, Clements Physical Therapy will verify and review your insurance benefits prior to providing treatment.
- We will file for you all insurance claims for services rendered, and make every effort to obtain reimbursement.
- Should your insurance company decline to pay for rendered services or should there be any remaining balance that is your responsibility, our billing office will forward a statement to you.
- Any unmet deductible, co-insurance, or co-payment according to your insurance benefits, will be collected at the time of service.
- We accept checks and credit cards for your payment. If a check is returned from our bank, there will be a $30 returned check fee added to you account. This fee will need to be paid at your next visit.
- At Clements Physical Therapy, we are dedicated to providing the best possible service for you. If you have any questions or concerns, please feel free to contact our office manager.
- See the following policies listed below with additional information pertaining to your insurance carrier.

Private and Commercial Billing and Payment Policies:

- Physical Therapy is usually covered under the major medical portion of most commercial insurance policies. Therefore, your insurance carrier may hold you responsible for a major medical deductible and co-insurance portion of the services you receive.
- Clements Physical Therapy will verify all benefits and inform you of those services your insurance carrier may not cover.
- Based on the information provided by your insurance company during insurance verification, we will estimate the portion of charges for which you should be responsible, taking into consideration coordination of benefits, should you have coverage under multiple insurance policies.
- If your insurance company requires prior authorization or precertification for treatment, we ask that you play a proactive part in order to be pre-approved.
- In the event that your insurance company considers our services to be "out of network," we will make every effort to accommodate their requirements and will work with you to ensure that you receive necessary care.

Medicare Billing and Payment Policies:

- Medicare covers our services under the Part B, major medical portion of your policy, Therefore, if you do not have a supplemental insurance policy, you will be responsible for satisfying your deductible and 20% of all Medicare allowed fees and we ask that you pay any applicable deductible and co-insurance amounts at each visit.
- We will inform you of any charges which we anticipate Medicare may not cover and ask that you pay for these services when rendered.

Worker's Compensation Requirement and Payment Policies:

- It is ultimately your responsibility to adhere to all conditions and policies set forth by your employer's workers compensation carrier to insure they will pay for our services, including but not limited to utilizing specific approved care providers and obtaining prior authorization for treatment.
- Most workers compensation carriers require prior approval/ precertification before services are provided. We ask that you confirm that each visit has been approved prior.
- In the event that your employer denies responsibility for your injury or you do not adhere to your employer's guidelines, you will be responsible for the charges that are incurred during the duration of your treatment.
- Please notify us immediately if it is determined that your employer will not be covering your injury, so we can discuss alternatives, such as billing your private health insurance. Our office is willing to work with you and coordinate with your health insurance company to insure that your receive the maximum benefits, as outlined in your policy.

Auto Insurance/ Accident Billing and Payment Policies:

- If your injury is a result of an auto or other accident for which a third party may be liable, the insurance for the other party likely will not agree to pay us until you have achieved your maximum recovery. Therefore, we cannot wait for this reimbursement.
- We will bill your personal auto or liability insurance, if indicated, as your primary payer, and we will then bill your personal health insurance. You will be asked to pay any deductibles and coinsurance portion at the time of service.
- If you retain an attorney to assist with reimbursement for this injury, please forward your attorney's name and phone number to us as soon as possible.

If you have any questions or concerns about our billing and payment policies, please feel free to ask our office staff. We are here to assist you through the process.

I have read and understand these billing and payment policies and my responsibilities in order to ensure appropriate reimbursement for services I receive.

Patient/ Responsible Party Signature _____Date_____

CLEMENTS PHYSICAL THERAPY

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

As part of my health care, **Clements Physical Therapy** (**Clements Physical Therapy**) 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 as a basis for my continuing care. I understand that this information is used as a means of communication among **Clements Physical Therapy**'s personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses 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 billed 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 **Clements Physical Therapy** 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 **Clements Physical Therapy** 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 and at the central billing office.

I understand **Clements Physical Therapy**, for **Workman's Compensation Cases**, will release the minimum necessary PHI/ePHI to your employer, your worker's compensation insurance carrier, third party administrator, rehab nurse or nurse case manager unless otherwise restricted below.

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 **Clements Physical Therapy** is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices.

☐ I DO NOT authorize my information shared with the following individuals or organizations (enter names below and initial the box):

_____

☐ I DO authorize my information shared with the following individuals or organizations (enter names below and initial the box):

_____

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

_____ _____

Signature of patient or legal representative Date

_____