Ft. Lowell Physical Therapy, P.C.

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Please Print **Account #** ________________ **Date:** ________________

Patient's Name:_________________________________D.O.B._____________Age:_________

Address:___________________________________City____________State_______Zip______

SS#:________________________ Home Phone:________________ Work Phone:___________

Cell Phone:__________________

E-mail Address: ____

How did you hear about us?____

Patient's Employer:_______________________________Occupation:______________________

Address:_______________________________City____________State_______Zip_________

Spouse's Name:_______________________________________SS#______________________

Employer:_______________________________________Occupation:_____________________

Address:___________________________________City____________State_______Zip______

Patient's **PREVIOUS ADDRESS: (**if less than six months at the above address)

Address:_____________________________City_______________State______Zip_________

Name of relative/friend **NOT** living with you:____

Relationship:____________________________________ Phone:_________________________

Address:________________________City___________________State_________Zip_______

Referring Physician:____

Primary Care Physician: ____

Type of Injury:_____________________________________ Date of Injury:__________________

(Please Select Yes or No)

MVA? Yes No
(Motor Vehicle Accident)

Third Party? Yes No
(The other Persons Insurance is Covering)

Work Related Injury? Yes No

Insurance Information

Primary Insurance Carrier:____

Address:___________________________City:_____________State:_____ Zip:________

Policy Holder:_____________________ ID#:_____________________ Group:_________________

Relationship to Insured: Self Husband Wife Dependent Other____________
(please select one)

Claim #:__________________________ Adjuster's Name:________________________________

Adjuster's Phone No.:___________________________ Ext.:____________________

Secondary Insurance Carrier:____

Address:___________________________City:_____________State:_____ Zip:________

Policy Holder:_____________________ ID#:_____________________ Group:_________________

Relationship to Insured: Self Husband Wife Dependent Other ____________
(please select one)

Claim #:__________________________ Adjuster's Name:________________________________

Adjuster's Phone No.:___________________________ Ext.:____________________

Attorney:____ Phone:_____________________

Address:___________________________City:_____________State:_____ Zip:________

ASSIGNMENT and RELEASE

I hereby authorize my insurance company to pay benefits directly to Ft. Lowell Physical Therapy and I am financially responsible for non-covered services. I also authorize Ft. Lowell Physical Therapy to release information to: **(please print in the name of requested Dr., Ins. Co., etc.)**

Referring physician:________________________ Primary care physician:____________________

Primary insurance company:_________________ Secondary insurance company:______________

Attorney (if applicable):____________________ Lien Solutions (if applicable):________________

Signature:______________________________ Date:___________________________________

Ft. Lowell Physical Therapy Financial Policy

Thank you for choosing us as your health care provider. **Our main concern is that you receive the proper and optimal treatments needed to restore your health.** Therefore, if you have questions or concerns about our fee or payment policies, please do not hesitate to ask.

Ft. Lowell Physical Therapy is pleased to file your **primary** insurance for you. However, the responsibility of keeping your account current is yours. Insurance coverage will be verified and based upon this information; you are financially responsible for any deductible, co-pay or the percentage not covered by your policy. There are times the benefits we are quoted do not coincide with how the claims are processed or what is in your insurance policy. It is your responsibility to understand your healthcare benefits and specifics of your policy. We do not bill secondary insurance companies. Please make sure the insurance information you are providing is correct. **Insurance information will not be changed unless your policy limits are exhausted.** You will be expected to pay for any balance beyond what your insurance carrier considers "Reasonable & Customary".

We are providers for several health insurance companies. If you were in a motor vehicle accident and request we bill your health insurance when there is either liability insurance, med pay insurance or a lien we will collect the monies discounted for being a provider at 100% of our fee schedule.

Your policy is a contract between you, your employer and the insurance company. If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier. If the insurance company does not pay in full within 45 days, we require you to pay the balance.

We will verify benefits for your secondary insurance upon request. Most insurance companies do not cover for supplies. If you receive a supply, we ask you pay for this item before leaving on the date of service.

If an insurance company pays you first and there is an outstanding balance, you are expected to pay us from that check immediately even if there is payment expected from another insurance company. We will refund any subsequent overpayment to you immediately. We require that you fill out the insurance information completely, leaving out no possible insurance companies that may pay your bill.

If an attorney is handling your case, we require that you sign an attorney's lien form and a payment and interest agreement. It is important that you also understand that in the event that no insurance company pays your bill and you do not receive a favorable settlement, you are still financially responsible for your bill. Any attorney/patient balance beyond 45 days will accrue an interest charge at 1 ½% on a monthly basis.

We understand that temporary financial problems may affect timely payment of your balance. **We encourage you to communicate any such problems so that we can assist you with a payment plan.**

I have read and understand the above policies.

Signature:________________________________ Date:_______________________

INFORMED CONSENT

I agree to allow the physical therapist and staff to evaluate and treat me or make other recommendations regarding treatment for my diagnosis (es).

APPOINTMENT POLICY

In order for **Ft. Lowell Physical Therapy** to provide fair and equitable scheduling, we have the following policies. All scheduling will be done on a "**first come first serve basis**". We will make every attempt to accommodate your schedule but may not always be able to provide you with the times you would like. It is the therapist's responsibility to communicate to you how many times per week you need to receive treatment. It is then the patient's responsibility to stop at the receptionist desk and schedule their appointments. Please **DO NOT** assume you will be automatically scheduled each week - you must confirm with the receptionist.

PLEASE CALL if you are going to be **LATE** for a scheduled appointment.

In order to **cancel** an appointment, **PLEASE CALL** at least **24 hours** in advance. Time is reserved for **you!** Failure to show or give sufficient notice of cancellation of a scheduled appointment within 24 hours will result in an **office charge** being applied to your account. **YOUR INSURANCE COMPANY WILL NOT COVER THIS.**

Your physician, case manager and rehabilitation consultant will be notified if you have:

1. two cancellations (no-shows) without giving notice, or

2. three consecutive cancellations

It is consideration, respect and commitment that make a mutually beneficial relationship. As professionals we strive to serve our patients to the best of our ability. We expect the same commitment from those we serve. Your cooperation is essential and truly appreciated. As we are committed to helping you achieve your treatment goals, we want the focus of your treatment to be on you. Therefore, we request that children and other family members remain in the waiting room unless they are involved in patient and family education.

As a courtesy to staff and other patients, please turn off your cell phone while you are in the building.

I have read the above informed consent, appointment policy and children policy and understand its implications.

Signature:____ Date:__________________________

Ft. Lowell PT Health Status Questionnaire

Name:____________________________________ **Date**:____________________
Gender: □ M □ F Date of Birth:______________
Occupation:________________________________ Currently working: □ Yes □ No
Smoker: □ Yes □ No Pregnant: □ Yes □ No
Current height:______________________________ Current weight:_____________

Past Medical History: Please check if you have, or have had:

- ❑ Cancer
- ❑ High Blood Pressure
- ❑ Heart problems (heart attack, angina, valve)
- ❑ Pacemaker
- ❑ Stroke
- ❑ Deep Venous Thrombosis (blood clots)
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Lung disease
- ❑ Allergies or asthma
- ❑ Diabetes before / after age 18
- ❑ Osteoarthritis
- ❑ Rheumatoid Arthritis
- ❑ Osteoporosis
- ❑ Hypothyroid (low) or Hyperthyroid (high)
- ❑ Epilepsy/seizures
- ❑ Headaches (more than 1 per week)
- ❑ Chemical dependency (alcohol or drugs)
- ❑ Depression
- ❑ Dizziness or vertigo
- ❑ Other:_______________________________

Past Surgical History: List and date:

____
____
____
____

Current Medications: Please list, or attach your own list.

Name of medicine, include dose and frequency	Reason for taking
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Special Questions: Please check any that apply:

- □ Change in bowel or bladder function
- □ Change in appetite
- □ Unexplained weight loss (>10 lbs)
- □ Increased pain at night
- □ Long term use of steroids
- □ Fever/chills/sweats
- □ Increased pain with coughing or sneezing
- □ Nausea/vomiting
- □ Numbness or tingling in both arms, or both legs
- □ Numbness in the groin or crotch area

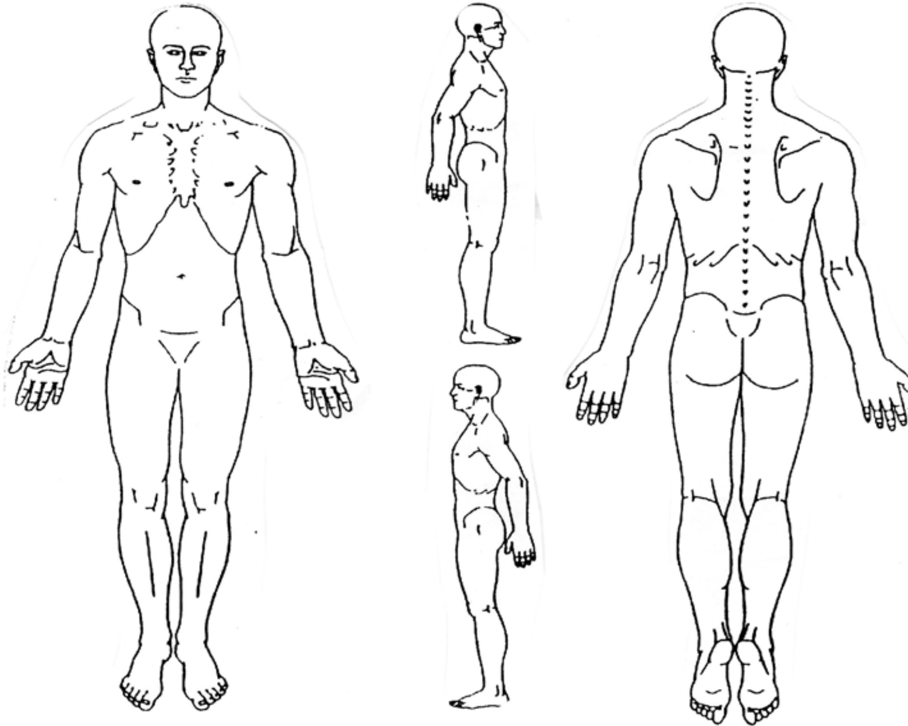
***Have you fallen over the past 12 months? □ Yes □ No**
If yes, how many times? ______________

Do you have allergies to steroids? □ Yes □ No
Do you have allergies to latex? □ Yes □ No

When (approximately) did your present pain start?____
How (gradually, suddenly, injury)?____

What treatments (if any) have you received for this problem so far?
____

Have you had an x-ray, MRI, or other imaging study for this problem? □ Yes □ No
Please describe your pain: □ sharp □ dull □ aching □ other:____________________
Please mark the areas where you feel pain:



Select the number that represents your **average** level of pain over the past week:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain

Select the number that represents your **worst** level of pain over the past week:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain

Select the number that represents your **best** level of pain over the past week:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain

Aggravating Factors: Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your problem:

____
____
____

What are your personal goals for physical therapy?

____
____

Consent: I understand that my diagnosis and treatment plan will be discussed during my appointment and that I have the right to question and/or refuse any treatment offered.

____________________________________ ____________________________________
(print name) (sign name)
Date:____________________________________

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Ft. Lowell Physical Therapy, P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Ft. Lowell Physical Therapy Notice of Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Ft. Lowell Physical Therapy reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Ft. Lowell P.T.

With my consent, Ft. Lowell P.T. may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care and account.

With my consent, Ft. Lowell P.T. may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as letters, patient statements and records.

With my consent, Ft. Lowell P.T. may fax to me or other designated locations any items that assist the practice in carrying out TPO, such as patient records. I have the right to request that Ft. Lowell P.T. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Ft. Lowell P.T.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Ft. Lowell P.T. may decline to provide treatment to me.

______________________________	______________________
Signature of Patient or Legal Guardian	Patient's Name
______________________________	________________
Print Name of Legal Guardian or Patient	Date