FORM PHYSICAL THERAPY

FUNCTIONAL ORTHOPEDIC REHABILITATION MEDICINE

ONE-ON-ONE PHYSICAL THERAPY

Patient Responsibility Agreement

We bill all insurance payers although we may not be contracted with all insurance companies. If we are a network provider for your insurance company, they will pay for our services at the negotiated rate and we will apply the appropriate payments and adjustments to your account. It is your responsibility to pay deductibles, copayments or coinsurances. All out of network charges will be negotiated as discussed per this agreement.

If pre-authorization is required, it is the responsibility of the provider to initiate the authorization process. If the authorization is not approved at the time of your evaluation, you will be given the option to have the evaluation without authorization and risk denial and financial responsibility or reschedule until authorization is approved. Upon the completion of your evaluation, we will bill your insurance.

Definitions:

Deductible- The deductible amount depends upon the type of plan that you have with your insurance carrier. This is the amount that must be paid by you prior to your insurance making any payments on your behalf.

Copayment- is a predetermined fee an individual will pay for health care services, in addition to what the insurance covers. For example, some insurance payors require a $10 copayment for each office visit, regardless of the type or level of services provided during the visit.

Coinsurance-is a predetermined percentage an individual will pay for health care services, in addition to what the insurance covers. For example, some insurance requires a 20% coinsurance. We will bill your insurance and apply all payments and adjustments. You will be responsible for the 20% that your insurance does not cover.

We have determined the following to be your responsibility per the phone call to your insurance company. **THIS IS NOT A GUARANTEE OF PAYMENT.**

Deductible: In_____ out_____

Amount: $_____ has_____ hasn't_____ been met for your benefit period.

Copay: _____ per visit

Primary Coinsurance: _____ Secondary Coinsurance _____

Payments will be accepted as follows for your treatment:

_____

_____

_____

Patient Acknowledgement:

_____	_____	_____
Printed Name	**Signature**	**Date**

Office Staff Signature: _____ Date:_____

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First Name _____ Last Name _____ Date of Birth _____ □ Male □ Female

Home Street Address _____ City _____ State _____ Zip _____

Cell Phone # _____ Home Phone # _____ E-Mail Address (important) _____

Emergency Contact _____ Relationship _____ Contact Phone # _____

Referring Physician _____ Primary Care Physician (if different than referral) _____

How did you hear about us? □ Physician □ Family/Friend □ Internet □ other_____

Primary Insurance _____ Member ID # _____ Provider Phone # _____

Secondary Insurance _____ Member ID# _____ Provider Phone # _____

Payment Options

□ I have insurance (please complete Assignment of Benefits Form authorizing us to deal with them for you)
□ I have a work related injury under worker's compensation
□ I was in an automobile accident going thru auto insurance
□ I will be "self-pay"
***Accepted forms of payment include: Visa, Mastercard, Discover Card, Check, Cash

***I understand that I am responsible for my payment or portion of payment due according to my health insurance benefits at the time of service. I authorize FORM Physical Therapy to evaluate me and initiate appropriate treatments.

Signature _____ Date _____

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**** If minor, I authorize FORM PT to treat my child/dependent: _____

PRE-EXAMINATION QUESTIONNAIRE

Have you had physical therapy before? □ Yes □ No Is Yes, Why? _____
_____

Please describe your problem: _____
_____
_____

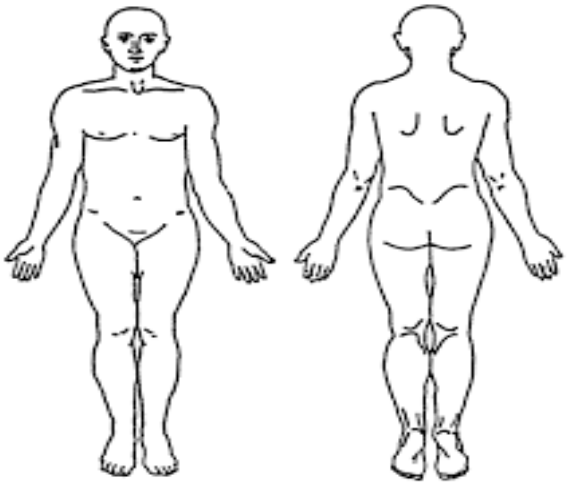
What caused your pain/problem? □ Unknown _____
_____

Approximately when did it begin? _______________
Is the pain/problem getting worse, better or staying the same? _____
What makes the problem better?_____
What makes the problem worse? _____

What activities are you unable to do now secondary to pain/problem?
_____

What are your goals in physical therapy or your recovery?
_____

Using diagram please mark your painful areas:



Score your pain level on your pain:
0 = no pain 5= pain limits you 10= ER admit

At best: 0 1 2 3 4 5 6 7 8 9 10
At worst: 0 1 2 3 4 5 6 7 8 9 10
Current: 0 1 2 3 4 5 6 7 8 9 10

Circle words that describe your pain:
Aching Burning Cramping Dull Numbness Radiating Sharp Sore Stiff Tight Tingling

How frequent do you feel your pain?
____ Intermittently < 25%
____ Occasionally < 25-50%
____ Frequently < 51-75%

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____ Constantly > 75%

For this problem, have you had any of the following: □Xray □MRI □CT Scan □EMG □Injection

Have you ever been diagnosed as having any of the following conditions?

Cancer	□Yes □No	Broken bone/Fracture:	□Yes □No
Type:_____		Type: _____	
Vascular issues	□Yes □No	Osteoporosis	□Yes □No
Heart Attack	□Yes □No	Osteopenia	□Yes □No
High Blood Pressure	□Yes □No	Diabetes	□Yes □No
Stroke	□Yes □No	Depression	□Yes □No
Deep Vein Thrombosis/DVT	□Yes □No	Headache	□Yes □No
Anemia/low blood levels	□Yes □No	Memory Problems	□Yes □No
Pacemaker/Defibrillator	□Yes □No	Hearing Problems	□Yes □No
Lung Problems	□Yes □No	Memory Problems	□Yes □No
Asthma	□Yes □No	Dizziness/Vertigo	□Yes □No

Other Conditions: _____

Surgeries:

Type: _____ Date _____
Type: _____ Date _____
Type: _____ Date _____
Type:_____ Date: _____

Current Medication:

_____
_____
_____

Do you have a latex allergy? □Yes □No Other allergies: _____

Do you exercise regularly? □Yes □No What type **and** how often? _____
_____

Have you fallen in the past year? □Yes □No When? _____
Check if you use: □ Cane □Walker □Crutches □Forearm Crutches □Manual w/c □Power w/c

_____ _____
Patient Signature Date

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By signing below, I acknowledge and consent to the following, where applicable:

1. **Medical Consent**: I authorize FORM Physical Therapy to perform physical therapy assessment and treatment which will be discussed with my therapist.
2. **Payment of Services**: I understand that payment is expected at the time of service and i am fully responsible for all fees that are not covered by my insurance except those prohibited by the insurance carrier. Insurance will be filed for services rendered as directed by me. Co-pays and Co-insurance are expected at the time of service.
3. **Cancellation Policy**: We require **24 hours notice** in the event of a cancellation. There is a **$40 charge for a cancellation** without proper notice. This charge will not be covered by insurance and you will be responsible for this charge personally. We review any emergencies, illness & discuss on a case by case basis to determine any justification to waive this fee.
4. **Notice of Privacy Practices**: By way of signature, I provide FORM Physical Therapy, LLC with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment, and healthcare operations as described in the Privacy Notice.
5. **Medical Insurance Benefits**: FORM Physical Therapy will verify my insurance coverage prior to service and filing clams. Based on this information FORM Physical Therapy will estimate the portion of charges for which I should be responsible, taking into consideration coordination of secondary insurance if primary insurance is a traditional Medicare policy.
6. **Medicare Authorization**: I certify the information given in applying for payment under the TITLE XVII of the Social Security Act is correct and requests payment of authorized benefits to be made on my behalf. I authorize FORM Physical Therapy to release to Medicare Bureau, Health Care Financing Administration or its intermediaries or its carriers, any information needed for Medicare claims. Including medical information for the purpose of processing of claim for Medicare benefits.
7.**Change of Insurance**: I understand that I am to inform FORM Physical Therapy if my insurance changes during treatment. If your claims are returned due to termination of your insurance, you will be responsible for full bill.
8. **Medical Records Release**: I authorize FORM Physical Therapy to release my medical records to any referring physician, insurance company, health care facility or government agency requesting such information.

I authorize the release of any medical information to the following person:

Name: _____ Relationship:_____

Patient Acknowledgement:

_____	_____	_____
Printed Name	**Signature**	**Date**