physical therapy for everyBODY

Patient Contact Information

Patient Name_____ Today's Date_____
Address_____City_____St_____ Zip_____
Date of Birth_____ Age_____ Gender_____ Marital Status_____
Email_____Cell Phone_____
Home Phone_____ Work Phone_____
Employer_____ Occupation_____

Parent/Guardian/Spouse
Name_____ Relationship_____
Address_____City_____St_____ Zip_____
Cell Phone_____ Home Phone _____

Emergency Contact
Name_____ Relationship_____
Address_____City_____St_____ Zip_____
Cell Phone_____Home Phone_____
Work Phone_____

Patient Questionnaire

Primary Care Physician_____How did you hear about us?_____
History of current condition_____
_____
_____
_____
_____
How is this condition keeping you from the things you need, want, or love to do?_____
_____
What do you want to gain from treatment?_____
_____
List any tests that have been performed and the results (ex: X-ray, MRI, CT Scan)_____
_____
_____

Have you had any other treatments for your current condition? (ex: chiropractic, PT, massage, etc.)
Please list practitioners._____

_____

Which treatments had a positive effect?_____

_____

Which treatments had a negative effect?_____

_____

Please list all previous injuries, accidents, surgeries (please include year), and any other pertinent medical information_____

_____

_____

Please list all medical conditions and/or health concerns_____

_____

_____

Please list all current medications_____

_____

_____

Please list all allergies_____

_____

Do you now have or have you had any of these symptoms in the past year?

☐ Change in bowel movements	☐ Persistent nose bleeds	☐ Shortness of breath
☐ Persistent joint pain	☐ Learning disabilities	☐ Recurring headaches
☐ Unexplained weight loss	☐ Tiredness/fatigue	☐ Depression/Anxiety
☐ Irritable bowel	☐ Difficulty sleeping	☐ Other_____
☐ Vertigo or dizziness	☐ Fainting spells	☐ Other_____

Dental history (please elaborate when possible):
Grind or clench your teeth?_____ History of TMJ?_____
Ever wear a dental splint?_____ Currently using a night guard?_____
Popping or clicking in jaw?_____ Jaw ever lock up?_____

For women only:
Please list number of pregnancies____ Number of children____ Date of last pelvic exam_____
Any pregnancy or delivery complications, menstrual prolems?_____

Do you now have or have you had any of these symptoms in the past year?

☐ Urinary incontinence	☐ Fecal incontinence	☐ Pelvic pain
☐ Pelvic prolapse	☐ Pelvic floor dysfunction	☐ Symphysis Pubis Dysfunction
☐ Pain in vaginal region	☐ Painful intercourse	

Office Policies and Procedures

Welcome to Physical Therapy for EveryBODY! At Physical Therapy for EveryBODY, we partner with people who desire improved daily function by using knowledge, experience, research and each patient's own values to create a customized plan for healing and rejuvenation.

Cancellation Policy

As a courtesy both to our office as well as other patients who want to be seen, we ask for 24-hour (or more) notice for cancellations, with obvious exceptions made for emergencies or illness. This allows others who are on waiting lists to be seen. We reserve the right to bill a $75 fee in cases of repeated missed appointments.

Informed Consent for Physical Therapy Services

The purpose of physical therapy is to treat disease, injury, and disability by examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures, mobilization, massage, and exercises to aid each patient in achieving their maximum potential. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific procedure or exercise protocol. Physical Therapy for EveryBODY, Inc does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for.

Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury. It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care.

I authorize the release of my medical information to appropriate third parties for the purpose of communicating with other health care professionals to improve patient care.

_____

Patient Name

_____ _____

Signature (Parent or Legal Guardian if under 18 years old) Date

Payment Agreement

Thank you for choosing Physical Therapy for EveryBODY as your physical therapy provider. Before we begin services, please initial below indicating you have read, understand and agree to the following payment policies.

_____**Financial Responsibility**. You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.

_____**Out-of-Network Policy.** Physical Therapy for EveryBODY is a fee-for-service clinic. This means that Physical Therapy for EveryBODY is not "in-network" with any private health plans. Payment is due at the time of service and we will not bill your insurance company.

_____**Receipts.** We can, upon request, provide receipts with diagnosis and treatment codes which you may submit to your private insurance company. Such receipts cannot be made available if you are a Medicare beneficiary. We strongly encourage you to contact your insurance company prior to your first visit if you are unsure what your out-of-network reimbursement may be.

_____We accept cash, personal checks, and credit cards.

_____(Medicare Beneficiaries only) **Medicare Policy.** If you are a Medicare beneficiary, you understand that our licensed physical therapists are not enrolled as Medicare providers. Medicare has onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide. Since the documentation and administrative processing of ourservices are not designed to meet Medicare's covered benefit requirements and we are not Medicare enrolled providers, **our services will not be covered (paid) in full or in part, by Medicare** (including Medicare Advantage Plans) even if the same services might be considered covered benefits when provided by a Medicare enrolled provider.

We will not submit claims to Medicare on your behalf or provide you with a statement or billing codes that you can submit to Medicare yourself. If you want Medicare to pay for any services that might be considered covered benefits, you should seek those services from a Medicare-enrolled provider.

By choosing to receive our services after being fully informed of these facts, you are agreeing, of your own free will, that you do not want Medicare involved in payment for your physical therapy services at Physical Therapy for EveryBODY. You agree to pay privately for the services you receive from us even if those services might be covered by Medicare if provided by a Medicare enrolled provider.

You also understand that since we are not enrolled Medicare providers and our documentation and administrative processes do not meet the technical requirements for Medicare to cover the services we provide, our services are not subject to Medicare's maximum allowable charge. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts, statements, or treatment notes to Medicare, a Medicare Advantage Plan, or to any primary-payer private insurance for reimbursement or to obtain a denial for a Medicare supplemental insurance plan.

_____**Privacy Rights.** You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. By paying for your services at the time of service, we assume you are exercising this right to privacy and we will not disclose your medical records to any third party, including your health insurance carrier or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Disclosure to Release Protected Health Information form before we will disclose your health information.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE WRITTEN STATEMENTS AND PAYMENT TERMS.

_____

Patient Name

_____ _____

Signature of Patient or Legal Guardian Date