PHYSICAL THERAPY Specialists and BALANCE CENTER
We put healing in motion

Welcome to Physical Therapy!

Please complete the following information to the best of your ability, and make sure each page is signed and dated.

PATIENT INFORMATION:

Name: _____ **Date of Birth:**____/____/_____ **Sex:** □Male □Female

Address: _____

City: _____ **State:** _____ **Zip:**_____

Home Phone: (_____)_____ **Cell:** (_____)_____ **Work:** (_____)_____

Preferred Number to Call: □Home □Cell □Work **Text Message Reminder:** □Yes □No

Email Address: _____

Last 4 Digits of your SS#: _____ **Marital Status:** □Single □Married □Divorced □Widow

Employer Name: _____

Employer Address:_____

Emergency Contact Name: _____ **Phone:** (_____)_____

INSURANCE INFORMATION:

Relationship: □Self □Child □Spouse □Employee □Other:_____

Plan Name: _____

Subscriber ID#:_____ **Group#:**_____

IF ANY OTHER THAN SELF, PLEASE COMPLETE THE BELOW:

Insurer Name: _____ **Date of Birth:**____/____/_____

Last 4 Digits of SS#: _____ **Address:** _____

Home Phone: (_____)_____ **Cell:** (_____)_____ **Work:** (_____)_____

Employer Name: _____

Employer Address:_____

ADDITIONAL INFORMATION:

Injury is Related to: □Work □Auto □Home □Sports □Other_____

Is a Home Health Agency Currently Providing Services in Your Home? □Yes □No

Do You Currently Reside in an Assisted Living or Nursing Home Facility? □Yes □No

How Did You Hear About Us? _____

Have You Had Any Therapy in the Last 12 Months? □Yes □No

If YES, Where Did You Have the Services? _____

Date of Injury/Onset of Condition:_____

Type of Injury:_____

Referring Physician:_____ **Primary Care Physician:**_____

Medical History Questionnaire

Name:_____ **Date:**_____

Height:_____ **Weight:**_____

Allergies (including Latex): _____

List all medications that you are currently taking, both prescription and over the counter. Please specify dosage and length of time taking medication. If you need additional room, please use the back of this form.

Medication	Dosage	Duration Prescribed

Have you fallen recently? □Yes □No **If yes, how many times?** _____

Do you use tobacco products? □Yes □No **If yes, how many times per day?** _____

Do you drink alcoholic beverages? □Yes □No **If yes, how many drinks per week?** _____

Are you pregnant? □Yes □No **If yes, how many weeks?** _____

Are you in need of social or vocational services? □Yes □No

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

Yes			Yes	
	Cancer			Infectious Disease
	Chest Pain or Shortness of Breath			Hepatitis
	Heart Disease			Headaches Frequent/Severe
	High Blood Pressure			Hearing/Vision Difficulties
	Pacemaker			Numbness or Tingling
	Heart Attack			Dizziness
	Stroke or TIA			Weakness
	Congestive Heart Failure			HIV/AIDS
	Blood Clots			Mental Health Issues
	Circulation Problems			**Surgery/Injury of any of the following:**
	Seizure Disorder / Epilepsy			Neck
	Thyroid Problems			Back
	Asthma/Emphysema/Bronchitis			Shoulder
	Chemical Dependency			Elbow
	Diabetes			Hand
	Rheumatoid Arthritis			Hip
	Other Arthritis Conditions			Knee
	Fibromyalgia			Ankle / Foot

If you answered "YES" to any of the above conditions, please explain: _____

_____

Patient (or Guardian) Signature:_____ **Date:** _____

Therapist Signature: _____ **Date:** _____

2022 Consent Form

Informed Consent

I consent to treatment rendered by Physical Therapy Specialists, as ordered, or approved by my physician. I agree to participate in Physical Therapy Specialists' program to the best of my ability to facilitate a rapid and full recovery.

I understand that some increase in pain may be normal. I must determine how much pain increase is acceptable to me, and I may be asked to describe any pain using a Visual Analog Scale. I will not be asked to perform activities that increase my pain to a level that is unsafe or undesirable to me. I will be asked to perform activities but will not be forced to perform any activity that I believe unsafe. I will be informed if I'm seen doing anything unsafe or that jeopardizes my recovery.

Consent for Release of Information

Insurers may release to Physical Therapy Specialists any information regarding the extent of my insurance coverage, information concerning the status of claims submits by Physical Therapy Specialists and information regarding payments made directly to me on those claims. Physical Therapy Specialists may obtain any information and/or medical records pertinent to "treatment" provides from hospital, physicians, nursing agencies, and other health care providers. Pursuant to the privacy rule 45CFR164.501 of HIPAA, "treatment" generally means the provision, coordination, or management of health care and related services among providers or by a health care provider with a third party, consultation between health care providers regarding a patient, or the referral of a patient from one health care provider to another.

Receipt of Privacy Practice Notice

I understand that Physical Therapy Specialists has provided me with a copy of their Notice of Privacy Practices, which states how my personal health information (PHI) may be used or disclosed and outlines my rights regarding this information. I understand that Physical Therapy Specialists has the right to change this notice at any time and that I must request in writing any objections to any of these "uses" or "disclosure". I may obtain an additional copy of this notice from this office per my request.

Please check of the following statements: ☐ I received a copy of the Privacy Practices ☐ I declined a copy of the Privacy Practices

I, a patient of Physical Therapy Specialists, give my expressed permission to discuss with the individuals I have listed:

☐ Any aspect of my health care ☐ Health Information only ☐ Financial information only

Name:_____ Relationship: _____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

I understand that I am responsible for notifying this office, in writing, of any changes to this authorization to disclose my personal health information.

Assignment of Benefits

I understand that I am ultimately responsible for the charges incurred for my services at Physical Therapy Specialists whether the benefits are through Commercial Insurance, Workers' Compensation or a Third-Party Payer (i.e. auto accident).

I also understand that additional information may be required of me to assist Physical Therapy Specialists in filing such claims. I may have to provide information from the following list regardless of my insurance:

- Social Security Number
- Date of Birth
- Copy of Insurance Card(for commercial filing and/or workers' compensation)
- Name of employer, employer address, phone number and contact person
- Auto Insurance

Physical Therapy Specialists will file my insurance claims as a courtesy and understands that any quoted benefits given at the time of service are not a guarantee of payment. I assign all benefits paid by the insurance to be paid directly to Physical Therapy Specialists. By my signature below I acknowledge my responsibility and assign said benefits and verify that I have read and agree to the terms of Physical Therapy Specialists Payment Policy.

_____ _____

Signature of Patient/Guardian Date

Payment & 24-HR Cancellation / No Show Policy

Payment

In an ongoing effort to better serve our patients, we will use reasonable efforts to obtain benefit information from your insurance carrier for outpatient rehabilitation services. Because your insurance carrier typically does not guarantee either the benefits it provides to us on your behalf, or the payment for services rendered to you, your carrier's benefit information which we provide to you **may not be completely accurate**. We will not know exactly what your coverage of expenses will be until we have received reimbursement from your insurance carrier at which time you are responsible for the balance of all unpaid claims.

We strive to make payment for your account balance as convenient for you as possible. Insurance companies require the separate filing of our professional fees for each date of service. As a courtesy to you, we customarily file your claims with your insurance company. Each patient, however, remains fully responsible for the entire amount of the bill until all claims are paid.

Payment for any deductible, co-insurance, or copayment is expected at the time services are rendered. If our staff is unable to confirm that you have insurance coverage, full payment of your charges may be requested at the time of service. Any payment due may be paid in cash, personal check, or credit card. There is a **3% usage fee on each credit/debit card transaction**. If your unpaid balance exceeds 30 days, the unpaid balance will be subject to a 1.5% finance charge each month (18% annually).

If you are unable to comply or if you have any questions concerning our payment policy, our Office Manager will be happy to assist you.

Overdue Account Balances

It is unfortunate when no arrangements for payment can be made or agreed upon arrangements become delinquent. Any account that is 90 days past due may be considered a bad debt risk. When this happens, we may have no recourse but to assign your account to a third-party collection agency for collection or place your account with an attorney to obtain judgment or otherwise satisfy payment of your delinquent account. If this occurs, a collection fee of up to 30% of the unpaid balance may be added to your account. We will also charge reasonable attorney fees, court costs, interest, late fees, sheriff's fees, and similar fees.

No Show/Cancellation Policy

Twenty-four-hours notice is required for all cancellations. Anytime you miss an appointment that you did not call to cancel or reschedule, is considered a no show. If this happens, you will be charged a **$35.00 no show fee**. Subsequent cancellations of appointments of less than twenty-four-hours will incur a **$25.00 late cancellation fee**. These fees must be paid by your next appointment. Three cancellations of less than twenty-four hours prior to appointment time or three no shows could result in discharge.

I, the undersigned, have read and understand the Payment and No Show/Cancellation Policy as outlined above.

_____ _____

Patient or Guardian Signature Date

Additional Services

The following services are offered in this clinic but are not covered by most insurances. Please read over and sign that you have read and understand. This is not a consent to receive these services. Consents will be signed prior to services being performed.

Electrical Stimulation

Electric stimulation therapy is a therapeutic treatment that we have used for many years. It applies electrical stimulation in treating muscle spasms and pain. Physical therapists and other medical practitioners attach electrodes on the patient's skin, causing the target muscles to contract. With electric stimulation, the patient can maintain muscle tone and strength that would otherwise waste away due to lack of usage.

E-Stim is not currently covered by most insurance companies. If your therapist feels this will be beneficial for you, we will offer the service at no additional cost to you. However, we do require that you purchase your leads for $10.00 (pk of 4) that we will keep here to use during your treatment, and then send home with you at discharge.

Dry Needling

We are pleased to offer Dry Needling treatment services. According to the American Physical Therapy Association, "Dry Needling is a skilled intervention that uses a thin fill form needle to penetrate the skin and stimulate underlying myofascial trigger points, muscular, and connective tissues for the management of neuromusculoskeletal pain and movement impairments. Dry Needling is a technique used to treat dysfunctions in skeletal muscle, fascia, and connective tissue, and diminish persistent peripheral nociceptive input, and reduce or restore impairments of body structure and function leading to improved activity and participation."

Your therapist may feel that Dry Needling treatment would be beneficial for you. At this time, most insurance companies will not cover the cost of Dry Needling treatment. The cost of this effective treatment is typically $30.00-$60.00, depending on the amount of time necessary for your particular treatment. Your first treatment is complementary. Most patients require 4-6 treatments.

Orthotics

Over-the-counter orthotics are appropriate for some patients and others do not need them at all, so discussing and evaluating you is the best way to decide if custom orthotics is right for you. We cast in the office during your appointment and order your orthotic inserts with PAL Health Technologies. While we will bill your insurance company for these services, a lot of insurance companies to do not cover this cost, and the fees can range anywhere from $150 to $300. Please let us know if you would like for us to call your insurance company to check on your specific cost and coverage.

Each service will be explained in detail by your therapist before you agree to these treatment options. By signing below, you acknowledge that you may be responsible for payment.

Patient Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Home Safety Checklist for Fall Hazards

This room-by-room checklist highlights possible fall hazards. If you mark "yes" to any of these questions, consider the suggestions to help reduce your chances of falling. We will keep a copy of this assessment and give you a copy to take home.

FLOORS: Look at the floor in each room.

Possible Hazard	Yes	No	Suggestions
When you walk through a room, do you have to walk around furniture?			Ask someone to move the furniture so your path is clear.
Do you have throw rugs on the floor?			Remove the rugs or use double-sided tape or a non-slip backing so the rugs won't slip.
Are there papers, books, towels, shoes, magazines, boxes or other objects on the floor?			Pick up things that are on the floor. Always keep objects off the floor.
Do you have to walk over or around wires or cords?			Coil or tape cords and wires next to the wall so you can't trip over them. If needed, have an electrician put in another outlet.

KITCHEN: Look at the kitchen and eating area.

Possible Hazard	Yes	No	Suggestions
Are the things you use often on high shelves?			Move items in your cabinets. Keep things you use often on the lower shelves (about waist level.)
Is your step stool unsteady?			If you must use a step stool, get one with a bar to hold on to. Never use a chair as a step stool.

BATHROOMS: Look at all your bathrooms.

Possible Hazard	Yes	No	Suggestions
Is the tub or shower floor slippery?			Put a non-slip rubber mat or self-stick strips on the floor of the tub or shower.
Do you need some support when you get in and out of the tub or up from the toilet?			Have a carpenter put grab bars inside the tub and next to the toilet.

BEDROOMS: Look at all your bedrooms.

Possible Hazard	Yes	No	Suggestions
Is the light near the bed hard to reach?			Place a lamp close to the bed where it's easy to reach.
Is the path from your bed to the bathroom dark?			Put in a night-light so you can see where you're walking. Some night lights go on by themselves.

STAIRS & STEPS: Look at the stairs you use both inside and outside your home.

Possible Hazard	Yes	No	Suggestions
Are there papers, shoes, books, or other objects on the stairs?			Pick up things on the stairs. Always keep objects off the stairs.
Are some steps broken or uneven?			Fix loose or uneven steps.
Are you missing a light over the stairway?			Have an electrician put in an overhead light at the top and bottom of the stairs.
Has the stairway light bulb burned out?			Have a friend of family member change the light bulb.
Do you have only one light switch for your stairs (only at the top or at the bottom?)			Have an electrician put in a light switch at the top and bottom of the stairs.
Is the carpet on the steps loose or torn?			Make sure the carpet is firmly attached to every step or remove the carpet.
Are the handrails loose or broken? Is there a handrail on only one side of the stairs?			Fix loose handrails or put in new ones. Make sure handrails are on both sides of the stairs.