Village
PHYSICAL THERAPY

PATIENT INTAKE FORM

Patient Name: _____ Date of Birth: _____

Home Address: _____

Primary Phone Number - Please Circle: (Cell/Home/Work): _____

Secondary Phone Number - Please Circle: (Cell/Home/Work): _____

Email Address: _____

What is your preferred method of communication? Phone call or Email (please circle one)

Emergency Contact Information

Name: _____

Phone Number: _____

Relationship to Patient: _____

How did you hear about us? (Please circle):

Doctor Friend Advertisement Other: _____

Whom are we billing for this service? (Please circle):

Health Insurance Workers Comp Auto Accident Self-Pay

For Medicare Patients Only:

Are you receiving or have you received Home Health care this year? €YES €NO

Have you been discharged from Home Health Care? €YES €NO

If yes, Date of Discharge: _____

Do you have a Medicare Advantage Plan? €YES €NO

Do you have a Supplement to Medicare? €YES €NO

*Please be aware that if you have Medicare and do not have a Supplemental Plan, you will be responsible for the 20% Medicare will not pay.

I agree that the above information is accurate:

X _____ **Date:** _____

Signature of Patient and/or Guardian and Relationship to Patient

Village
PHYSICAL THERAPY

PATIENT MEDICAL HISTORY FORM

Patient Name: _____ Date of Birth: _____ Date: _____

Family Doctor (PCP): _____ Referring Physician: _____

Location of injury/pain: _____ When did pain start/Date of Injury: _____

Have you had surgery for this injury? **YES** **NO**

- If Yes, Type of Surgery: _____ Date of Surgery: _____

Have you had any of the following diagnostic or medical services for this injury/episode?

	YES	NO		YES	NO
Physical Therapy			X-Rays **If yes, Date:** _____		
Occupational Therapy			MRI **If yes, Date:** _____		
Massage Therapy			CT Scan **If yes, Date:** _____		
Chiropractor			EMG/NCV **If yes, Date:** _____		
Orthopedist			Emergency Room		
Neurologist			Other:		

Do you now or have you ever had any of the following?

	YES	NO		YES	NO
High Blood Pressure			Arthritis (OA / RA)		
Heart Disease			Osteoporosis		
Heart Attack or Surgery			Gout		
Pacemaker			Headaches		
Asthma, Bronchitis, or Emphysema			Vertigo (Past or Current)		
Shortness of Breath or Chest Pain			Dizziness or Fainting		
Stroke/TIA			Numbness or Tingling		
Diabetes (Type 1 or 2)			Bleeding disorder (blood thinner?)		
Cancer/Chemotherapy/Radiation			Problem with ears (hearing aid?)		
Epilepsy or other seizure disorders			Problem with eyes (glasses/contacts)		
Metal Implants (Including bullets, staples, plates, IUDs, etc.)			Are you pregnant? Due date? _____		
Broken Bones			Falls		
Weight Loss/Energy Loss			Do you Smoke?		
Allergies (latex, tape)			Other:		

Surgical History (Please list all prior surgeries including Joint Replacements):

Type of Surgery: _____ Date: _____ Surgeon: _____
Type of Surgery: _____ Date: _____ Surgeon: _____
Type of Surgery: _____ Date: _____ Surgeon: _____
Type of Surgery: _____ Date: _____ Surgeon: _____

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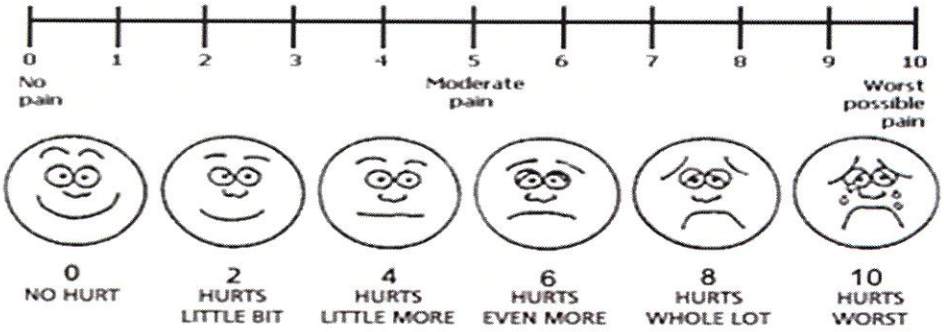
PATIENT MEDICAL HISTORY FORM CONT.

What is your current level of pain? (please circle a number)



Are you currently taking any medications? (including: prescription/over the counter/supplements)

Anti-inflammatories YES NO If **YES,** Please Specify: _____

Muscle Relaxers YES NO If **YES,** Please Specify: _____

Pain Medication YES NO If **YES,** Please Specify: _____

All other medications:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Please list any additional information that would assist us in providing care to you?

_____

_____

What are your expectations and goals?

_____

_____

By my signature below, I certify that the information I have provided above is complete, accurate and truthful to the best of my knowledge.

Patient Name (printed): _____

X _____ **Date:** _____

Signature of Patient and/or Guardian and Relationship

X _____ **Date:** _____

Signature of Physical Therapist

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PHYSICAL THERAPY

PATIENT CONSENT FORM

CONSENT TO TREATMENT

I consent to receive rehabilitation therapy treatment and any supplementary services that are deemed medically necessary or appropriate by my therapist and/or treating physician. However, I understand that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/or the treatment results from the rehabilitation therapy.

I understand that consistent attendance and adherence to the planned treatment regimen is paramount to my care and recovery.

HIPPA

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be use to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly
- Obtain payment from third-party payers

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (Printed)_____

X_____ **Date:**_____

X_____ **Date:**_____

Signature of Provider Representative/Witness

Village
PHYSICAL THERAPY

OFFICE POLICY

We are dedicated to providing you with the best possible health care and we are ready to help you receive your maximum allowable benefits if you have medical insurance. In order to achieve these goals, we need your assistance, and understanding that:

- Your insurance is a policy between you, your employer, and the insurance company. *We are not a party to that contract.*
- Verification of benefits is a courtesy that we extend to our patients. However, **it is the patient's responsibility to know their benefits**. We are not always able to obtain the details of your plan because we are not the subscriber or the employer.
- Our fees reflect current market price. Our clinic offers rehab services at substantially less cost than a larger institution.
- Each insurance company determines what Physical Therapy services are covered and at what cost they will cover. Not all services are a covered benefit in all policies. Please call your insurance company for your detailed benefits. The member service number is on the back of your card
- All co-payments and past due balances are expected at the time of service. For patients with deductibles and co-insurance: once we receive the allowed amount from the insurance company, we will provide you with a statement balance.
- After you are discharged, we will mail you a final bill for all charges you are financially responsible for regardless of any applicable insurance or benefit payments, third-party interests, or the resolution of any legal action or lawsuits in which you may be involved.
- We accept Cash, MC, Visa, AMEX, and Discover cards. There is a $25.00 service charge on all returned checks
- We offer a cash payment plan for patients who don't have insurance or for those who have a high deductible plan.
- It is the responsibility of the patient to call and cancel scheduled appointments within 24 hours. Any person missing 3 appointments due to no shows or cancellations is subject to discharge.
- We are happy to communicate via email, but please understand we don't have an encrypted email. We cannot guarantee the email will be secure and confidential.
- Medical information/office notes will be faxed to your referring physician to provide a continuum of care. Records will be sent to an insurance carrier only if requested by the carrier to pay a claim.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

X _____ Date: _____

Signature of Patient and/or Guardian

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LIABILITY POLICY

If your injury or condition is the result of a work-related injury or due to a motor vehicle accident please read:

- We require that you supply us with the appropriate billing information: insurer, claim #, date of injury, case manager, adjuster, and point of contact and phone numbers.
- We require that an insurance card be on file for all patients who are filing a worker compensation and liability claim. In the event your claim is denied we will bill the insurance carrier on file. If the claim is denied by the insurance carrier, you will be responsible for full payment.

Workers' Compensation. If your injury is work-related, we will bill your company's workers' compensation carrier if you have filed an injury report with your employer and your right to workers' compensation benefits is not in dispute. If you are informed that a dispute about your right to workers' compensation benefits has arisen after you have begun treatment with us, you agree to inform us immediately. You will have a choice at that time to pay for your treatment out of pocket or allow us to bill your health insurance. In the event you do not have health insurance and cannot pay privately, we will discuss your options with you at that time.

Auto or other Liability Insurance. If an auto or other liability insurer is responsible for paying your claims, you hereby assign your Med Pay/Personal Injury Protection (PIP) or other applicable benefits to us for the payment of our claims. You further agree to give us a lien on any settlement, judgment or insurance proceeds you receive for payment of any and all unpaid claims, including late payment interest and authorize your attorney to pay us out of the settlement/verdict proceeds. In the event your auto insurer or other liable party denies our claims or refuses to honor the assignment, we may, at our sole discretion, bill your health plan. If we do, you will be responsible for refunding any fees owed to your health plan when you settle your case. Lastly, other than releasing health records with your consent, we don't do business with attorneys.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

X _____ Date: _____

Signature of Patient and/or Guardian

X _____ Date: _____

Signature of Provider Representative/Witness

Village
PHYSICAL THERAPY

PATIENT FINANCIAL POLICY

PAYMENT AGREEMENT:

- I agree to pay Village Physical Therapy all amounts that are due and owing for services rendered which are not otherwise paid for by an insurance plan, third party payor, or other payor source on my behalf.
- I acknowledge in the event that my benefits have been exhausted or claims have been denied, I will be responsible for payment in full.

- I acknowledge that if I have not met my deductible then I will pay the estimated visit rate for my insurance company. This amount will be applied to amount described as "patient responsibility" according to the insurance company's EOP and I will be billed for any remaining balance due.

- I acknowledge if my account goes unpaid beyond 30 days it is considered past due. I understand that I can set up a payment plan with the billing department without penalties.

- **Late Payment Penalty.** A late payment penalty in the amount of __5__% on unpaid claims will be added every month that your claims go unpaid after you are discharged from our care. You agree to be personally responsible for paying such penalties unless applicable law requires your health plan or other responsible Payor to pay it.
- All overdue balances greater than 180 days will be sent to collections.

  Collection Actions. You understand that we are not required to obtain your written authorization to disclose protected health information to a collection agency or court of law that may be necessary to collect payment for services rendered. Should collection proceedings or other legal action become necessary to collect an overdue account, you will be responsible for paying the collection costs plus court costs and filing fees incurred by the practice.

In-Network Claims. If we are in-network with your health plan, we will submit the claims to your health plan on your behalf and your health plan will send payment directly to us. If your health plan denies payment of our claims, in whole or in part, you are responsible for paying any and all unpaid amounts within thirty (30) days of receiving our statement regardless whether you have filed or plan to file an appeal. You hereby assign and convey directly to Village Physical Therapy all health plan benefits

PATIENT FINANCIAL POLICY -continued-

and/or insurance reimbursement benefits otherwise payable to us for medical services, treatments, therapies and/or examinations rendered or provided by us. You authorize Provider to release all medical information necessary to process my claims to the responsible Payor. You also agree that if any payments

are sent to you despite your assignment of benefits to us, you will promptly forward the funds and explanation of benefits/payment to Provider.

Out-of-Network Claims. If we are out-of-network, payment is expected in full at the time of service unless you have made other payment arrangements with us. We may, at our sole discretion, agree to set you up a payment plan or make other payment arrangements. We will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. We may agree to bill your health plan for our services directly and await payment from your health plan if you execute the assignment of benefits agreement below. You agree that if your health plan does not honor the assignment and sends payment to you, you will promptly forward the payments to us. You further agree that if your health plan denies payment of our claims, in whole or in part, you are responsible for paying any and all unpaid amounts within thirty (30) days of receiving our statement regardless whether you have filed or plan to file an appeal.

Cash Payment Policy. We offer a discounted cash payment rate when patients pay cash at the time of service in exchange for the prompt payment and the reduction in administrative work/time since we don't have to file claims or obtain pre-authorization. This cash payment discount is offered to patients who do not have insurance or who choose not to use their health plan benefits. If we are in-network with your health plan, our cash payment rate *may* be less than the in-network rate that we have negotiated with your health plan. If you choose to take advantage of our discounted cash payment policy, you understand that we will not submit a claim to your health plan and agree that you will not submit our claims or statements to your health plan in an attempt to get reimbursed for our services. If you choose to pay cash initially and later want to switch to using your health plan, you understand that the fees for our services may be higher and you will no longer be entitled to our discounted cash price. Your ability to switch to using your health plan benefits may also be limited by your health plan's requirements for pre-authorization or other policy limitations.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

X _____ **Date:** _____

Signature of Patient and/or Guardian

X_____ **Date:** _____

Signature of Provider Representative/Witness