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New Patient Information Sheet

Name: _____ Date of Birth: _____ M_____ F_____

SS #: _____ Marital Status: S__ M __ D __W __ Email:_____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work: _____

Primary Dr: _____ Primary Dr. phone_____ Fax:_____

Referring Dr.:_____ Referring Dr. phone _____Fax: _____

Employer: _____ Address: _____

City: _____ State:_____ Zip:_____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Account Responsibility: Self_____ Spouse_____ Other:_____ Name: _____

*How you were referred to us? i.e. Facebook, friend, Google _____

Primary Insurance Name: _____ Phone #: _____

Subscriber Name: _____ Relationship: _____ Date of Birth: _____

Policy ID #: _____ Group #: _____

Secondary Insurance Name: _____ Phone #: _____

Subscriber Name: _____ Relationship: _____ Date of Birth: _____

Policy ID #: _____ Group #: _____

How will you pay for your copay, coinsurance and/or deductible? Cash____ Check____ Credit Card____

*****PLEASE PRESENT YOUR INSURANCE CARDS TO THE RECEPTIONIST FOR COPYING*****

Patient Signature: _____ Date: _____

Physical Therapy Now, L.L.C.

PATIENT MEDICAL HEALTH QUESTIONNAIRE

Name: _____ Age: _____ Sex: M F Date of Evaluation: _____

Weight _____ lbs. Height: _____ Marital status: M S D W

Main Problem (How and when it started): _____

_____

Other recent treatment: _____

Tests (x-ray, MRI, etc.): _____

Surgeries (What and when): _____

Medications currently using: _____

_____

Allergies to tape, soap, latex, medication, other: _____

Please explain: _____

MEDICAL SCREENING
(Circle Yes or No)

Have you been told that you may have or have been treated for:

Arthritis/joint problems	Yes	No	Hepatitis	Yes	No
Angina/chest pain	Yes	No	Hernia	Yes	No
Asthma	Yes	No	Joint replacement	Yes	No
Balance problems	Yes	No	Kidney disease	Yes	No
Blood disease	Yes	No	Neck or back problems	Yes	No
Blood pressure	Yes	No	Nerve damage/disorder	Yes	No
Blood thinner currently	Yes	No	Numbness/tingling	Yes	No
Bowel or bladder problems	Yes	No	Osteoporosis	Yes	No
Bronchitis	Yes	No	Pacemaker	Yes	No
Cancer	Yes	No	Pregnant currently	Yes	No
Circulation/phlebitis	Yes	No	Rheumatic fever	Yes	No
Depression	Yes	No	Seizures	Yes	No
Diabetes	Yes	No	Shortness of breath	Yes	No
Dizziness	Yes	No	Spinal surgery	Yes	No
GERD	Yes	No	Stroke	Yes	No
Headaches	Yes	No	Tuberculosis	Yes	No
Hearing problems	Yes	No	Ulcers	Yes	No
Heart disease	Yes	No	Unexplained weight loss	Yes	No
Heart attack	Yes	No	Vomiting	Yes	No

I currently have difficulty…….check all that apply:

( ) driving ( ) getting up from a chair
( ) walking ( ) bending at the waist
( ) standing ( ) lifting

How are you able to sleep at night? (check one)

( ) fine ( ) moderate difficulty
( ) only with medication

Are your symptoms: (check one)

( ) getting worse ( ) the same
( ) improving

Do you or have you in the past smoked tobacco? (Please circle) Yes / No

If yes, # packs _____ number of years _____

Last tobacco use _____

PHYSICAL THERAPY NOW, LLC.

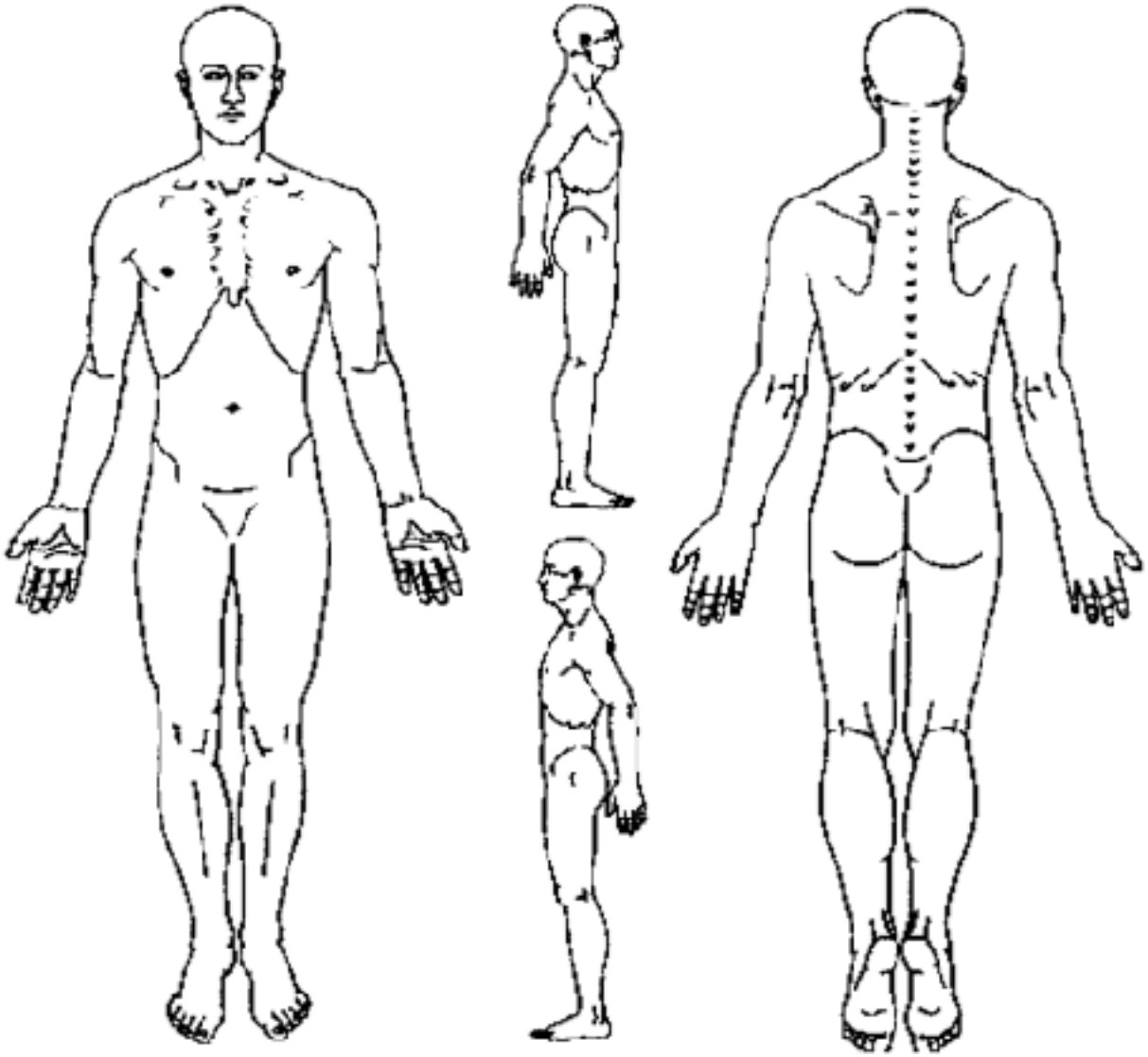
www.physicaltherapynow.net

PATIENT PAIN DIAGRAM

NAME _____ DATE _____

How long have you had pain? _____years _____months _____weeks _____days

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now.



A = ACHE	B= BURNING	N = NUMBNESS
P = PINS & NEEDLES	S = STABBING	O = OTHER

Place the above alpha characters on the diagram, indicating the locations and symptoms of your pain.

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CONSENT TO TREATMENT

I consent to physical/occupational and/or speech therapy evaluation and treatment by a licensed physical/occupational/speech therapist employed or contracted with Physical Therapy Now, LLC.

I can expect the therapist to explain to me the purpose of the evaluation and proposed treatment plan. The therapist will explain to me the expected outcome in addition to the risks that I may encounter from receiving skilled therapy care. I understand that my condition may worsen if I decline to receive treatment.

I also understand that physical/occupational and/or speech therapy treatment does not always provide beneficial results and though unlikely, may even increase my complaints. I am aware that I am encouraged to ask questions and can expect satisfactory responses from the treating therapist.

I have read this consent form and completely understand its contents. The physical/occupational / speech therapist is present to witness my signature of consent.

Patient or responsible person:

_____ _____

Print Name Signature

_____ _____

Relationship of responsible person if not signed by patient Date

I certify that I have fully explained the purpose, benefits, complications and available treatment options to the proposed evaluation and treatment. I have completely answered all patient questions to the best of my knowledge/ability. In my opinion the patient/responsible person completely understands all of my explanations/answers to their proposed questions.

_____ _____

Therapist Name (please print) Date

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Physical Therapy Now LLC the use or disclosure of individually identifiable health information for the purposes of Treatment, Payment and Health Care Operations.* I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

** **Treatment** includes activities performed by a health care provider, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician.*

** **Payment** includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.*

** **Health Care Operations** includes the necessary administrative and business functions of our office.*

** **Video Recording** may occur during the treatment session. This information may be used to assess further treatment options.*

You have the right to revoke this Authorization at any time, providing that you do so in writing and except to the extent that we already used or disclosed the information in reliance on this Authorization. Unless revoked earlier or otherwise indicated, this authorization will expire on the last day of the year in which these forms were signed.

Patient Information (Please Print):

_____ _____ _____

Last Name *First Name* *Middle Initial*

_____ _____

Signature of Patient or Representative *Date*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received PHYSICAL THERAPY NOW'S Notice of Privacy Practices for protected health information.

_____ _____ _____

Patient Name (please print) *Signature of Patient or Representative* *Date*

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ASSIGNMENT OF INSURANCE BENEFITS

I authorize and direct my insurance carrier to pay to Physical Therapy Now, LLC. as it's interests may appear, all benefits under my insurance policy now due or that may become due as a result of therapy services provided to me. I am responsible for all financial obligations of therapy services provided, and for reimbursement and payment of claims from my insurance company. If for any reason the account should become delinquent, I agree to pay for all interest charges, collection costs and any reasonable legal fees. I accept responsibility for payment of any deductible and co-insurance from my insurance policy.

I authorize and direct Physical Therapy Now, LLC to furnish any and all information and record of treatment and services rendered to me related to this claim. If I have decided to receive physical therapy services on a private pay basis and will not utilize my insurance benefits for any reason, I agree to pay the out-of-pocket rate determined before or at my first hour session. All private pay transactions are nonrefundable.

It is the policy of Physical Therapy Now, LLC to accept payment for services rendered from your participating insurance. However, most insurance companies require the patient to pay a co-pay, and/or a deductible. **Per insurance contractual obligations, we are required to collect all payments at the time of treatment *unless payment arrangements are made prior to your treatments.*** This would be the time to discuss payment arrangements with our staff concerning this policy.

Deductibles and out-of-pocket payments will be billed to your home address. Payment plans can be arranged so that lump sum payments can be avoided. You are encouraged, again, to discuss payment arrangements at the time of the evaluation. You are aware that physical, occupational, and speech therapy copays usually apply per each visit as determined by your specific insurance plan and treatment visits are usually 2-3 times per week per discipline as determined by your treating therapist. Please discuss the frequency of visits with your therapist before the beginning of treatment as you will be responsible for all copays, deductibles and out of pocket money as determined by your insurance company.

At Physical Therapy Now LLC, we are primarily concerned with your health! Therefore, **PLEASE DO NOT** be discouraged from attending your therapy or scheduling future appointments based on payment of co-pays and deductibles determined by your health insurance carrier. Please review your insurance policy to determine possible co-pays and deductibles that your insurance company has pre-determined, and that you may be obligated to pay. We will be more than happy to arrange a payment schedule that will fit your budget.

My signature below acknowledges that I do understand the above policy and plan of Physical Therapy Now LLC. While understanding this policy, I do agree to pay all co-pays and deductibles determined by my insurance company that are owed to Physical Therapy Now LLC., for evaluations and treatments by this company.

_____ _____

Patient name (Print) **Responsible Party (Print)**

_____ _____

Patient/ Responsible Party Signature **Date**

_____ _____

Signature of Therapist **Date**

PHYSICAL THERAPY NOW, LLC.

Fox Chapel **Allegheny Valley** **Pittsburgh** **PTN/Vesla 360**

MISSED APPOINTMENTS
CANCELLATIONS/NO-SHOW POLICY

You play the biggest role in the success or failure of your treatment. We have found that the following is crucial in ensuring a positive outcome:

- Attending your scheduled appointments
- Following and performing home programs (if applicable)
- Following Physician and PT recommendations and instructions
- Contacting your therapist if a difficulty arises with your treatment

If you are unable to keep your scheduled appointment time, please notify the office by calling within **24 HOURS** of your appointment time. There may be unforeseen emergencies that will prohibit you from calling and that will be taken into consideration by our office if you make the effort to call and explain those reasons at a later time.

Failure to provider 24 hour notice may result in a $35 cancellation fee.

This charge WILL NOT be covered by insurance, and will have to be paid by you personally.(24 hours means 24 business day hours, weekend cancellations for Monday appointments will be charged)

No-Shows will be an automatic $50 charge.

"No-Shows" are when a patient is not here or has not contacted us before the appointment start time.

- Your fee will be donated to **Generation House of Worship,** a non-profit church in Natrona Heights, dedicated to helping families in our area.
- Compensation and Personal injury patients, documentation of any missed appointments is forwarded to your Case Manager and Primary Care Physician, which could jeopardize your claim.
- Please understand that your pain may increase and decrease as your course of treatment progresses. Either example can seem to be a reason not to keep your appointment:

    1. You're feeling worse and think the treatment is not working or making you worse.
    2. You're feeling better and think you don't need to come anymore.

Neither of these are legitimate reasons not to come.

When you do not come to your scheduled appointment three people are hurt: YOU because you don't get the treatment you need as prescribed by the doctor; the THERAPIST who now has a space in their schedule since the time was reserved for your personally; and ANOTHER PATIENT who could have been schedule for treatment if you had given proper notice.

We ask for your cooperation regarding this issue and we look forward to working with you.
I have read and understand this policy:

PATIENT SIGNATURE_____DATE_____

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Please complete the information below to pay the amount that your insurance does not cover. For example, copays, deductibles and coinsurance. For our cash patients, we will bill your card for your self-pay visits.

All information is kept confidential and is securely stored in our business office.

Thank you.

PATIENT CREDIT CARD INFORMATION

Patient Name:_____

Patient email:_____

Name on Card:_____

Card Type:_____**Visa** _____**Mastercard** _____**Discover**

Card #_____

Expiration Date: Month_____ **Year** _____**Security Code:(3digit from back of card)**_____

Patient Signature:_____ **Date:**_____

Office Signature:_____ **Date:**_____

Every effort will be made to make the patient aware of their financial responsibilities as they arise. As a result patients have found that it is easier to leave a credit card on file with us for convenience. I authorize Physical Therapy Now to automatically charge my credit card balances due to the company at the time of treatment. This may include all copays, coinsurances, and deductibles or balances outstanding to Physical Therapy Now. Every effort will be made to make you aware of all financial responsibilities. Thank you.

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Office use only

PATIENT NAME: _____ **INITIAL EXAM DATE**_____

Updated 3/30/17