Physio Pro — A physical therapist owned private practice

Patient Information

To ensure accurate billing, our office will require all information is updated before every re-start or new treatment of care.

Name (Last, First, MI): _____ Social Security Number: _____

Date of Birth: ____/____/____ Age: _____ Marital Status: Single Married Divorced Widowed Gender: M F

Home Address: _____
(street address) (apt/unit #) (city) (state) (zip)

Billing Address: _____
(street address) (apt/unit #) (city) (state) (zip)

Home #_____ Cell #_____ Work #_____

Email:_____ Are you interested in appointment reminders? TEXT EMAIL

Employer:_____ Occupation:_____

Emergency Contact:_____ Relationship: _____ Phone:_____

Have you had previous physical therapy treatment? YES NO Treatment Area:_____

Dates of Treatment:_____ How many visits did you receive?_____

Are you currently or have you recently had Home Health Therapy? YES NO If yes, what is your discharge date?_____

Please provide all your current insurance information to the front desk.

Insurance Policy Holder:_____ DOB:_____ Relation:_____

For Auto or Work Compensation Patients: Please note we do not accept third party claims!

Company:_____ Claim #_____ Date of Injury:_____

Adjuster/Nurse Case Manager:_____ Phone #_____

Is an attorney involved in your case? YES NO

Attorney:_____ Phone #_____

-Please Turn Over-

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Please review the provided information packet including our HIPAA and payment policy before signing. Please note that without acknowledgement of our policies we may refuse or delay non-emergency services.

Consent to Treat:

I authorize Physio Pro P.C. to render services deemed medically necessary for the treatment of the above named patient. I have read and agree to Physio Pro P.C.'s Notice of Privacy Practices (HIPAA).

*Initial*_____

Financial Responsibility:

I understand that it is my responsibility to know my insurance benefits and any referral/authorization requirements. Any balance after insurance has paid or denied my claims will be my responsibility to pay. I also agree that failure to pay any balance due to me will result in my account being turned over to a collection agency. I aware I am responsible for any reasonable collection fees, including any attorney fees.

*Initial*_____

Payment Policy:

I have read and understand Physio Pro P.C.'s payment policy.

*Initial*_____

Assignment of Benefits/Medical Release of Information:

I authorize payment to be made directly to Physio Pro P.C. I authorize the release of any medical information necessary to process payment for services rendered.

*Initial*_____

Cancellation/No-Show Policy:

I have read and understand Physio Pro P.C.'s cancellation and no-show policy. I understand payment for missed appointments will be due before my next scheduled appointment.

*Initial*_____

I certify that all of the above information is true and correct. I will notify

Physio Pro P.C. of any changes to my personal or insurance information immediately.

Signature (Patient/Guardian):_____ Date:_____

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Patient History Form

Name (Last, First, MI):_____ Date:_____

Please describe your condition or symptoms:_____

_____

Surgery Date (if applicable): _____Have you missed any work due to your condition? YES NO

Date your condition or symptoms began:_____

Initially seen for this condition on (date): _____by Dr._____

Who referred you to our clinic? _____ Primary Care Physician: _____

May we send your PCP updates on your condition? YES NO

Please rate your pain level: no pain = 0 1 2 3 4 5 6 7 8 9 10 = worst pain

Do you have numbness or tingling? YES NO If yes, where? _____

Prior to onset, were you free of these symptoms? YES NO Explain: _____

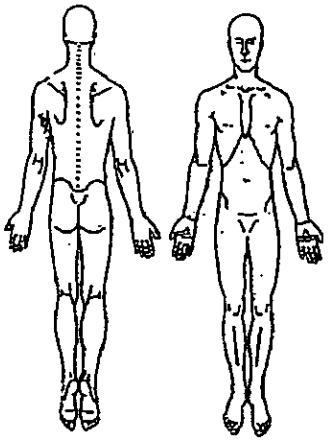
What eases these symptoms? _____

What aggravates these symptoms? _____

Have you had any treatment for this condition? YES NO Did it help? YES NO

What type and where? _____

Have you had X-rays / MRI / Arthrogram? YES NO Findings: _____



On the diagram please draw or depict your pain:

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Please list any surgeries or injuries (fractures, dislocations, sprains, etc.) for which you have been treated or hospitalized.

Include approximate dates. _____

_____

What are the most important things you hope to accomplish with physical therapy? _____

_____

In order to be in compliance with all **Medicare Requirement**, we need the following information from you:

1. Height:_____ft., _____inches,

2. Weight:_____lbs.

3. A list of current medications including dosage and frequency:

Medication:	**Dosage:**	**Frequency:**
_____,	_____mg.,	_____x per day
_____,	_____mg.,	_____x per day
_____,	_____mg.,	_____x per day
_____,	_____mg.,	_____x per day
_____,	_____mg.,	_____x per day
_____,	_____mg.,	_____x per day
_____,	_____mg.,	_____x per day
_____,	_____mg.,	_____x per day
_____,	_____mg.,	_____x per day

Patient Signature: _____ **Date:** _____

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Physio Pro, P.C., Payment Policy

Physio Pro P.C. is committed to provide exceptional to care to all our patients. In order to do so we require full patient participation in regards to treatment and billing. Please carefully read our payment policy below and feel free to ask for any clarifications.

1. Proof of insurance: We will require a copy of your photo ID and insurance card prior to your first appointment. Our office must be notified immediately regarding any change of insurance to minimize any additional financial responsibility to the patient. This includes but is not limited to a new insurance company, new insurance card and/or the beginning of a fiscal or benefit year. This is to insure our billing office always has complete and up-to-date information about your insurance.
2. Insurance: Physio Pro participates in most insurance plans. It is *your* responsibility to know if your insurance is accepted at our clinic. Please know there are certain employee plans within a network we accept that does not allow treatment at our clinic. It is again *your* responsibility to know if that includes your plan. If you do not provide your insurance information at the time of service we may require you to self-pay until your information is received. Please check with our front desk for our current rates. Please contact your insurance company with any questions regarding your plan. Our office will verify benefits as a courtesy to all our patients. However, we also strongly encourage our patients to contact their insurance company to ensure the information we are given is accurate. Our office will not be held responsible if your insurance provides inaccurate information.
3. Authorizations/Referrals: Some insurance plans require authorization and/or a referral prior to your initial appointment. It is a patient responsibility to know if either is required by your insurance. It is also a patient responsibility to make sure authorization is in place before each visit. Failure to have a required authorization or referral before an appointment may result in the patient being fully financially responsible for that treatment.
4. Deductibles/Co-Insurance and Co-Payments: Patient's will be responsible for annual deductible, co-insurance and co-payments. Co-payments are due at the time of service and may be subject to a $5.00 billing administrative fee if not paid. It is our policy to request that patients pay toward their annual deductible and co-insurance rates at the time of service. Your payment will be based on your benefits with your insurance company. In the event your insurance does not have a set collectible amount you will be required to make the minimum payment each visit for your insurance as determined by Physio Pro P.C.. Please check with our front desk in regards to your financial responsibility each visit. **Minor Patients** are still required to make a payment before services are rendered. Please make arrangements if an adult does not accompany the patient at the time of service. Failure to pay before you or your child's visit may require non-emergency appointments to be rescheduled to the *next available* appointment. For your convenience we accept cash, check and all major credit cards. Returned checks will be subject to a $30.00 non-sufficient funds fee.

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5. Non-Covered Services: Please be aware that some, if not all, of your services you receive may be non-covered or not deemed medically necessary by Medicare or other insurers. You must pay for these services and sign any paperwork required by your insurance for these services before you receive them.
6. Claims Submissions and Coverage Changes: Your insurance is a contract between you and your insurance company. Physio Pro, P.C. is not a party to that contract. As a courtesy, Physio Pro P.C. will submit your claims to your insurance company. It is your responsibility to make sure all of your claims are paid. It will be your responsibility to comply with your insurance company if any information is needed from the insurance company to process your claim. If you have any insurance changes Physio Pro must be notified immediately. Failure to provide insurance changes in a timely manner may cause denied claims. Any denied claims will be billed directly to you, the patient.
7. Delinquent Accounts/Refunds: You will have 90 days to pay any balance billed to you. If you do not pay your full balance within 90 days your unpaid balance will be referred to a collection agency. It is your responsibility to pay for any collection costs, including attorney fees. Due to administrative costs involved to process patient refunds, no refunds will be issue under $30 unless approved by management.
8. Cancellations and No-Shows: We require at least 24 hours notice for cancellations. For cancellations less than 2 hours before your appointment we will charge a $25 fee. Upon your first no-show you will be charged $40.00 and upon your second no-show you will be charged $75.00. If you have no-showed three or more times, Physio Pro P.C. will reserve the right to discharge you from our care. These charges must be paid before you are seen again. Please check in with the front desk periodically or refer to our notices board in the waiting room for any changes. If you are discharged, you will be required to be re-evaluated before you can be seen again. **It is your responsibility to keep track of your appointments.** For your convenience, Physio Pro P.C. offers text message or email appointment reminders. Please notify the front desk if would like to participate.
9. Late Arrivals: Any patient more than 15 minutes late will be required to reschedule to the *next available* appointment unless otherwise approved by the treating therapist. Your appointment is reserved for you and it is essential that you are compliant with your appointments and arrive on time for us to provide the best treatment possible.

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Notice of Privacy Practices (HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please read completely.

Uses and Disclosure of Your Health Information

Treatment - Your health information may be used by staff members as a means to provide, coordinate and manage your healthcare with one or more providers.
Payment - Your health information can be used to obtain payment for services, billing and collections, benefit verification and utilization review.
Healthcare Operations - Your Health Information can be used to manage all aspects involved in the daily management of our practice. This is including, but not limited to customer service, auditing and financial reporting and quality management.
Law Enforcement - Your health information will be disclosed to any law enforcement agency, without your permission, as required by law.
Public Health/Abuse or Neglect - Your health information will be disclosed to public health agencies and required by law. Your health information may also be used to alert the appropriate authorities if you are suspected to be a victim of abuse, neglect, domestic violence or other crime. Only necessary information will be used to prevent any threat to your health or safety or the health or safety of others.

Other Uses - Your health information used for any purpose other than those listed above will require your specific written authorization. You may revoke said authorization at any time in writing. Any revocation of authorization will not apply to any disclosures before the time Physio Pro, P.C. Is notified of such changes.

Family and Friends - Your information may be used to obtain assistance from family or other persons to assist in your healthcare or to obtain payment. We may only do so at your request.
Appointment Reminders - Your health information may be used to send you appointment reminders per your request.
Technology - If you provide your email, your health information may be used to communicate regarding your care. We may send you information regarding goods and services that we believe may interest you.

Your Rights as a Patient--

-The right to request restrictions regarding the use and disclosure of your health information

-The right to receive confidential communications regarding your condition and treatment

-The right to request an amendment and/or correction to your health information. We may deny your request under certain circumstances but will keep a copy of your request on file.

-The right to receive an accounting of how we or our business associates disclosed your health information.

-The right to inspect and copy your health information. You must make your request in writing. We will charge a reasonable fee to copy your records as compensation for supplies and staff time.

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NOTICE OF PRIVACY PRACTICES CONTINUED

Our Responsibility - We are required by law to provide you a copy of your Notice of Privacy Practices. We are also required by law to maintain the privacy or your health information and outlined in this notice. We reserve the right to amend or modify our privacy policies and practices. These changes may be required to comply with changes in federal or state laws and regulations. We will notify you immediately of any changes and will make copies of any changes available at our facility for your request.

Questions or Complaints - If you would like to submit a question, comment or complaint regarding our privacy practices, please do so in writing to our privacy officer. You may also submit any complaints with the U.S. Department of Health and Human Services. We support your right to protect your health information and will not retaliate in any way should you choose to file a complaint.

Contact Information -

Privacy Officer
Physio Pro P.C.
3801 E Florida Ave., Suite 330
Denver, CO 80210

U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, DC 20201

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