

## PATIENT INFORMATION

Name: \_\_\_\_\_

Date: \_\_\_\_\_

SS# (insurance requirement): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_

Driver's License: \_\_\_\_\_

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Physical Address (if different): \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer: \_\_\_\_\_

May we leave a detailed message at home? ☐ Yes ☐ No Cell ☐ Yes ☐ No

Would you like to receive appointment reminders? ☐ No ☐ Yes, by (choose 1):

☐ Text ☐ Phone ☐ E-mail

Parent/Spouse Name: \_\_\_\_\_

DOB & SS#: \_\_\_\_\_

Parent/Spouse Employer: \_\_\_\_\_

**Emergency Contact** (someone not living with you)

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

### **Medicare Patients Only**

Have you had any Physical Therapy or Home Health in the past year? \_\_\_\_\_. If yes, when and where? \_\_\_\_\_

Are you currently receiving Home Health (bathing, aide help, therapy, nurse visit)? \_\_\_\_\_ If you are currently receiving Home Health or have received Home Health in the past 3 months please **STOP HERE** and speak to or call the receptionist at (806) 467-8181.

## **INFORMED CONSENT FOR TREATMENT**

### **Complete if Over the Age of 18 Years Old**

The undersigned, being over the age of eighteen (18) years and being under no disability or prohibition that would in any way prevent or affect the Consent and Release, does hereby represent that, I \_\_\_\_\_ (patient), consent to rehabilitation treatment as prescribed by my provider.

### **Complete if the Patient is Minor or When the Adult Patient is Not Competent**

In the treatment of \_\_\_\_\_ (minor/adult patient \_\_\_\_\_, patient representative, of said minor/adult consent to rehabilitation treatment as prescribed by minor's/adult's provider. My relationship to the patient is (i.e. parent, son, daughter, etc) \_\_\_\_\_.

I certify that the information I have provided is complete and true to the best of my knowledge.

I give my authorization for treatment records to be released to the responsible payor for reimbursement consideration, or medical facility necessary for treatment or further care. Additionally, I request that any medical records requested by this facility, necessary for treatment or further care, be forwarded to this facility upon its request.

I understand that I am financially responsible for all charges whether or not paid for by said insurance (i.e. deductible amounts, co-insurance, co-pay, or any other balance not paid by my insurance). If this account is assigned to an attorney for collection and/or suit, the facility shall be entitled to reasonable attorney's fees and costs of collection.

I request that payment of authorized benefits be made on my behalf to this facility. I assign the benefits payable to which I am entitled to this facility for services rendered. This assignment will remain in effect until revoked by me in writing. A photocopy and/or facsimile of this assignment is to be considered as valid as an original.

I understand I may request and be provided a copy of Notice of Privacy Practices for TOTAL PHYSICAL THERAPY (TPT) and that TPT reserves the right to modify the privacy practices outlined in the notice. I have been issued a copy of TPT's Financial Policy and understand the terms of such policy and agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. This agreement applies to previous, current or future transactions.

I have read the aforementioned and I understand. Any questions that have arisen or occurred to me have been answered to my satisfaction.

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Patient or Patient Representative Signature

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Date

**FINANCIAL POLICY: PLEASE READ & PROVIDE YOUR INITIALS AT THE BOTTOM OF FORM**

You may request a copy of this policy agreement with our front office.

This is an agreement between **Total Enhancement Therapy, LLC dba Total Physical Therapy**, as creditor and the Patient/Debtor named on this form.

In this agreement the words "you", "your", and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "ours" refer to **Total Enhancement Therapy, LLC dba Total Physical Therapy**.

By executing this agreement, you are agreeing to pay for all services that your insurance carrier recognizes as patient responsibility.

**Insurance:** On your behalf we will contact your insurance company to verify coverage and benefits regarding out-patient physical therapy per your policy. Insurance is a contract between you and your insurance company. An insurance card must be made available to us before you are seen as a patient. Even though we may estimate what your insurance will pay, it is the Insurance Company that makes the final determination of your eligibility and responsibility. You are responsible for any amount as determined by your insurance carrier such as co-pays, coinsurance at the time of service which may be paid by cash, check or credit card (MasterCard or Visa).

**Required Payments:** Any co-payments required by an insurance company must be paid at the time of service. This is required by your insurance. Coinsurance (i.e. % insurance does not cover) will be handled on a case by case basis.

**Billing for Patient Responsibility:** Our policy is to bill all patients throughout duration of treatment. In the event that you are billed for services, payment is expected timely, unless prior arrangements have been made.

**Payments:** Unless we approve other arrangements, the balance of your statement is due and payable when the statement is issued, and is past due if not paid within 21 days. No more than 3 monthly statements will be sent if payment is not received.

**Past due accounts:** If your account becomes past due (over 90 days), we will take necessary steps to collect this debt. If we have to refer your debt to a collection agency, you agree to pay additional collection costs incurred from delinquency fees, address searches, credit reports or attorney fees which can possibly equal 50% of the balance due. We may also take the claim to Small Claims Court. You agree to pay any court fees incurred in trying to collect the past due balance. We have the option to report your account status to any credit reporting agency such as credit bureaus.

**Payment if you have no insurance:**

You choose to pay cash, check or credit card (MasterCard, Visa, or Discover) on the day that treatment is rendered. Payment plans may be available on a case-by-case basis. Please let us know today if you will be needing arrangements for a payment plan

**Returned checks:** There is \$25.00 fee for any checks returned by the bank. We prefer payment in cash on accounts with history of a returned check.

**Waiver of confidentiality:** You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if you're past due status is reported to a credit reporting agency, the fact that you receive treatment at our office may become a matter of public record.

**Workers' Compensation:** We require authorization by your workers' compensation carrier (not employer) prior to your initial visit. If your claim is denied, you will be responsible for payment in full. If your case is in dispute, we will require payment at the time of service until we receive information stating your employer's carrier will pay for services. Please remember that in order to receive your Work Comp benefits, you must keep your appointments.

**Personal Injury (motor vehicle accident):** We require payment of our private pay rate prior to each visit/treatment and we will gladly provide you with statements demonstrating your out-of-pocket expenses to submit to your attorney for settlement purposes. The remaining balance will be submitted to your attorney for payment upon settlement. Payment of all incurred charges/total bill ultimately remains your responsibility. You also acknowledge that your signature also serves as an Assignment of Health Care Benefits and you authorize your attorney or liability carrier to pay those lien amounts directly to **Total Physical Therapy** out of any settlement proceeds without further authorization from you.

**Co-signature:** If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent changes.

**Medical Records:** I hereby understand that I will be assessed of fee of \$25.00 (for first 20 pages and \$.15 for each additional page) for preparation of my medical records.

**Effective date:** Your signature in the Patient Information becomes the effective date and you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. This agreement applies to previous, current or future transactions.

**Missed appointments:** We strive to respect the rights of all patients to access therapy services by maintaining continuity of scheduling. Understand that therapy requires regular attendance to be optimally effective. It is our goal to give personal and quality care and thus an appointment time is reserved for YOU. In appreciation of our commitment to you we respectfully ask you to commit to TPT through regular attendance of your scheduled appointments and timely notification should you be unable to attend your sessions. It is understandable that unexpected events will happen and TPT will acknowledge these on a case by case basis.

## **ATTENTION !!**

PLEASE ACKNOWLEDGE BELOW indicating you understand and accept Total Physical Therapy missed appointment policies.

### **INITIALS:**

\_\_\_\_\_ I understand if I am more than **15 minutes** late to an appointment, my treatment time may be shortened and/or I may be asked to reschedule.

### **INITIALS**

\_\_\_\_\_ I understand if I cancel or no show **three** appointments, this may result in termination from therapy. TPT will notify my physician or case worker of this inability to maintain my appointments.

### **INITIALS**

\_\_\_\_\_ I understand that failure to provide **24 hour notice** for a cancellation and no show appointments can subject me to a **\$25 cancellation fee per occurrence**. This is billed directly to you and **not** covered by insurance. These fees will be applied to your next scheduled appointment and **payment is due at time of service.**

It is Total Physical Therapy's mission to provide excellent quality of care to you on each visit. Your commitment to your appointments helps us maintain this quality of care and helps to minimize your total number of treatments. It is always our goal to satisfactorily assist your condition in as few numbers of visits as possible. We thank you for your cooperation.

I have read through TPT Financial Policy and agree to the terms and conditions.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

# TOTAL PHYSICAL THERAPY

Name: \_\_\_\_\_ Referring Provider: \_\_\_\_\_ Date \_\_\_\_\_

**When** did your symptoms/problems begin? \_\_\_\_\_

Briefly describe history of your problem(s) for which you are seeking guidance:

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**If applicable** please **rate your pain** on a scale from 0-10 (where: 0 = no pain, 10 = Emergency Room)

At its **Worst**: \_\_\_\_ /10, **Current**: \_\_\_\_ /10, At its **Best**: \_\_\_\_ /10

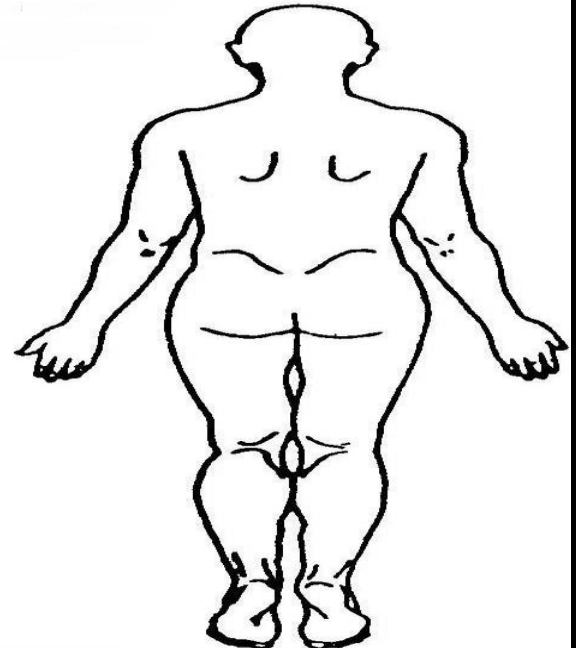
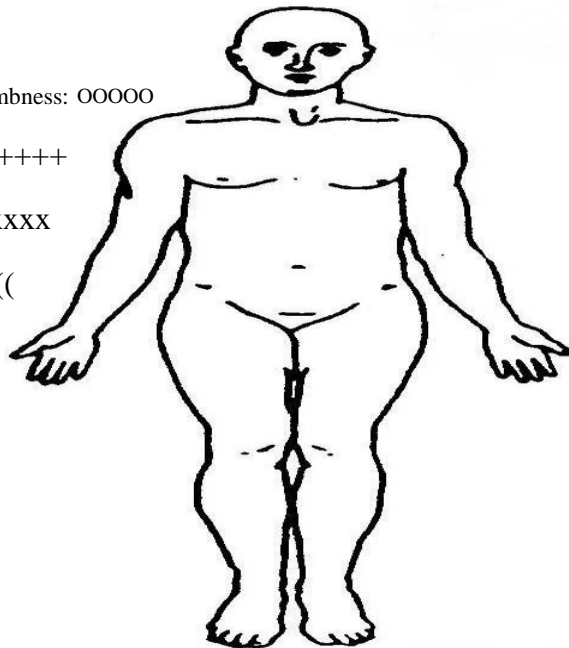
Please mark the location and type of your pain using the following key:

Pins/Needles/Numbness: OOOOO

Stabbing Pain: +++++

Burning Pain: XXXXX

Aching pain: (((((



Please list your **occupation/job title** (if applicable) \_\_\_\_\_

Working Status: ☐ Full time ☐ Part time ☐ Disabled ☐ Not currently working

Have you **fallen** in the past 12 months? ☐ No falls ☐ 1-3 falls ☐ More than 3 falls

**Past Medical History: Please check if you have or had any of the following** (check all that apply)

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> No Medical History   | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Genetic Disease      | <input type="checkbox"/> Pacemaker           |
| <input type="checkbox"/> AIDS                 | <input type="checkbox"/> Emphysema              | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Epilepsy/Seizures      | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Prostate Disease    |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Glaucoma               | <input type="checkbox"/> Low Blood Pressure   | <input type="checkbox"/> Repeated Infections |
| <input type="checkbox"/> Blood Disorders      | <input type="checkbox"/> Heart Attack/Heart     | <input type="checkbox"/> Lung Disorder        | <input type="checkbox"/> Skin Disorders      |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Lyme's Disease       | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Head Injury/concussion | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Thyroid Disorder    |
| <input type="checkbox"/> Cystic Fibrosis      | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Multiple Sclerosis   | <input type="checkbox"/> _____               |
| <input type="checkbox"/> Depression           | <input type="checkbox"/> High Cholesterol       | <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> _____               |

**Past Surgical History:** ☐ No surgeries to date (Please use back of page for additional space)

1. \_\_\_\_\_ Date: \_\_\_\_\_ 2. \_\_\_\_\_ Date: \_\_\_\_\_  
 3. \_\_\_\_\_ Date: \_\_\_\_\_ 4. \_\_\_\_\_ Date: \_\_\_\_\_

Please list any **allergies:** ☐ No known allergies ☐ \_\_\_\_\_

**WEIGHT:** \_\_\_\_\_ pounds **HEIGHT:** \_\_\_\_\_

**Please provide a goal(s) that you hope physical therapy can meet for you:**

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**Please tell us how you discovered Total Physical Therapy** (check all that applies):

- |  |   |
|--|---|
| <input type="checkbox"/> Physician suggested Total Physical Therapy (TPT).     | <input type="checkbox"/> I have family currently or previously seen at TPT.   |
| <input type="checkbox"/> Physician gave me a list to choose from. I chose you. | <input type="checkbox"/> A friend recommended you. If so who _____            |
| <input type="checkbox"/> Someone in my physician's office recommended you.     | <input type="checkbox"/> Internet search or social media.                     |
| <input type="checkbox"/> Your location is best for me.                         | <input type="checkbox"/> Telephone book                                       |
| <input type="checkbox"/> Decision based on insurance company.                  | <input type="checkbox"/> Handouts/Flyers/Newsletters/Community Advertisements |
| <input type="checkbox"/> I have previously been a patient at TPT.              | <input type="checkbox"/> Anything else: _____                                 |

**Instructions:** Choose the best answer for “How have you felt over the past week?”

- |   |     |    |
|---|-----|----|
| 1. Are you basically satisfied with your life?                  | Yes | No |
| 2. Have you dropped many of your activities and interests?      | Yes | No |
| 3. Do you feel that your life is empty?                         | Yes | No |
| 4. Do you often get bored?                                      | Yes | No |
| 5. Are you in good spirits most of the time?                    | Yes | No |
| 6. Are you afraid that something bad is going to happen to you? | Yes | No |
| 7. Do you feel happy most of the time?                          | Yes | No |
| 8. Do you often feel helpless?                                  | Yes | No |
| 9. Do you prefer to stay at home, rather than going out?        | Yes | No |
| 10. Do you feel you have more problems with memory than most?   | Yes | No |
| 11. Do you think it is wonderful to be alive right now?         | Yes | No |
| 12. Do you feel worthless the way you are right now?            | Yes | No |
| 13. Do you feel full of energy?                                 | Yes | No |
| 14. Do you feel that your situation is hopeless?                | Yes | No |
| 15. Do you think that most people are better off than you are?  | Yes | No |

**We welcome you to Total Physical Therapy and thank you for your time!**

**Medications:** Please provide a list of all prescription medications, over the counters, supplements, herbals that you are currently taking. If you have a list, we can photocopy for your convenience.

<b>Medication</b>	<b>Dosage</b>	<b>Frequency</b>	<b>Route</b> (mouth, topical, injection, etc)