FIRST PHYSICAL THERAPY, LLC

Get your life back!™

Welcome to First Physical Therapy! Today your therapist will perform an evaluation and develop a treatment plan including the frequency and duration of your treatment visits. Your care team will continually re-evaluate your progress and send regular reports to your physician/healthcare provider.

Insurance Information

We verify your insurance benefits as a courtesy, based solely on the information given to us by a representative of your plan or online through the provider portal(s). This verification is **not a guarantee** of payment until your insurance company has processed your claims. If you have any questions regarding how your plan processes your claims, it is your responsibility to confirm your benefits with your insurance company. Please inform the front desk of any updates or changes to your insurance. Failure to do so could result in a denial from your insurance, in which case you will be responsible for payment.

All co-payments and non-covered charges are due at each visit. First Physical Therapy, LLC does not bill insurance for Durable Medical Equipment. **You are responsible for payment for the following:** Kinesiotape, Theraband, Electrode Pads, and any other supplies. Inquire with your therapist or the front desk for the cost of these items. Coinsurances and deductibles are due after the insurance has processed the claim. We accept payment in the form of cash, check, MasterCard, Visa, Discover, and American Express. Payment plans are available.

Cancellation Policy

It is important to comply with your plan of care and keep your scheduled appointments. We ask that you kindly give us 24-HOUR NOTICE FOR ANY APPOINTMENT CANCELLATION. We have voicemail for your convenience during non-working hours, weekends, and holidays. If you do not call to cancel your scheduled appointment, or call to cancel after your appointment time has passed, it is considered a "no-show".

- **THERE IS A $40.00 FEE FOR EACH "NO-SHOW" APPOINTMENT.**
- **EXCESSIVE LAST-MINUTE CANCELLATIONS WILL BE SUBJECT TO A $25 FEE PER APPOINTMENT CANCELED NOT RECEIVED 24 HOURS IN ADVANCE.**

You will be personally responsible for this charge as insurance companies do not reimburse for fees due to lack of compliance. After three consecutive missed appointments, First Physical Therapy, LLC reserves the right to discharge your case.

Your signature below indicates that you understand and agree to comply with our office and payment policies.

_____ _____

Patient/Guardian Name Date

FIRST PHYSICAL THERAPY, LLC

Patient Information Form

PATIENT DEMOGRAPHIC INFORMATION

Last Name	First Name	Middle Initial
Preferred Name/Nickname	Date of Birth	
Address	City / State / Zip Code	
Mobile Phone	Email Address (*optional for appointment reminders only*)	
Home Phone / Work Phone	Sex ☐ F ☐ M	Status ☐ Single ☐ Married ☐ Other

EMERGENCY CONTACT INFORMATION

Contact Name	Phone	Relationship to Patient

PHYSICIAN INFORMATION

Referring Physician	Phone
Primary Care Physician	Phone

ADDITIONAL QUESTIONS

Allergies	Injury/Onset Date	Surgery Date (if applicable)	Body Part(s) to be Treated

Work Related ☐ Yes ☐ No If Yes, complete additional paperwork	Auto Accident Related ☐ Yes ☐ No If Yes, complete additional paperwork	Attorney Involved ☐ Yes ☐ No If Yes, complete additional paperwork
Have you had prior therapy this year? ☐ Yes ☐ No PT / OT/ ST/ Chiropractic	How did you hear about us?	

MEDICARE ONLY ADDITIONAL QUESTIONS

Are you currently receiving Home Health Services? ☐ Yes ☐ No	*If yes*, date of discharge

PRIMARY INSURANCE		SECONDARY INSURANCE	
Insurance/Plan Name		Insurance/Plan Name	
Policy ID#		Policy ID#	
Group#		Group#	
Patient relationship to policy holder ☐ Self ☐ Spouse ☐ Child		Patient relationship to policy holder ☐ Self ☐ Spouse ☐ Child	
Name of Policy Holder (if other than patient)	DOB	Name of Policy Holder (if other than patient)	DOB

I authorize First Physical Therapy to release all information obtained during my treatment to my insurance company(-ies), referring physician, and employer (for Workers' Compensation cases only). I authorize payment for services rendered be made directly to First Physical Therapy. I understand that I am responsible for all charges denied by insurance if my policy is terminated, the service is not covered, or limits determined by my insurance company have been exceeded.

Please Note: Charges will appear on your insurance Explanation of Benefits/Credit Card/Billing Statements as ***Focus Physical Therapy, LLC***

X_____ X_____

Signature of Patient or Representative **Date**

Relationship and authority to sign, if not patient: _____

FIRST PHYSICAL THERAPY, LLC

Name: _____ Date: _____

Have you ever been diagnosed with any of the following (check all that apply)?

- ❑Cancer (type)_____
- ❑Heart disease/TIA
- ❑High blood pressure
- ❑Lyme disease/Babesiosis
- ❑Pacemaker/defibrillator
- ❑Osteoporosis
- ❑Heartburn/ulcers/acid
- ❑Stroke
- ❑Depression/anxiety
- ❑Gallbladder disease
- ❑Lung problems
- ❑Thyroid disorder
- ❑Arthritis (type)_____
- ❑Osteoporosis/osteopenia
- ❑Diabetes
- ❑Multiple sclerosis
- ❑Kidney/liver problems
- ❑Blood clots
- ❑Parkinson's disease
- ❑Other_____
- ❑Allergy (list):_____

Please list current medications (or attach separate list):

Did you have previous physical therapy in this calendar year? Y/N # of Visits: _____

Are you experiencing any of the following:

- ☐ Difficulty breathing
- ☐ Swelling in your legs Did it worsen recently? Y N
- ☐ Increased fatigue
- ☐ Loss of strength
- ☐ Muscle cramping
- ☐ Numbness and/or tingling
- ☐ Pulsating (feel a heartbeat) in your abdomen
- ☐ Abdominal pain in addition to shoulder pain
- ☐ Symptoms related to food intake Are you taking anti-inflammatories? Y N
- ☐ Emphysema or COPD
- ☐ Changes in bowel or bladder habits Describe: _____

List any surgeries (include dates if you know them):

_____

_____

List *recent* tests done for <u>this condition:</u> (Xray, MRI, CT Scan, EMG, Nerve Conduction)

_____

_____

Regarding your current condition, please rate your pain: ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

No pain Need to go to ER

Currently_____ At the worst _____ At the best _____

What is your chief complaint? _____

What are your physical therapy goals? _____

Do you smoke? Y/N How many per day? _____ **Do you drink alcohol?** Y/N How often? _____

FIRST PHYSICAL THERAPY, LLC

Permission to Verbally Discuss Protected Health Information

Many of our patients allow family members such as a spouse, parents, children or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to share this information without the patient's consent. If you wish to have your information verbally released to family members/friends, you must sign this form. This form **does not authorize releasing copies of your medical records.** *Completion of this form is optional.*

Patient Name:		Date of Birth:	
Patient Street Address:	City:	State:	Zip:
Home Phone:	Cell Phone:		

I give permission for First Physical Therapy to **VERBALLY** share the information I have checked with the individual(s) I have identified below as being involved in my health care or payment of my health care. (Check all boxes that apply)

- ☐ Scheduling/Appointment Information
- ☐ Medical Information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Billing and payment information

First Physical Therapy has my permission to discuss the above information with the following family/friend/other:

1. Name: _____
   Address: _____
   City, State, Zip: _____
   Phone: _____

2. Name: _____
   Address: _____
   City, State, Zip: _____
   Phone: _____

3. Name: _____
   Address: _____
   City, State, Zip: _____
   Phone: _____

I understand that I have the right to revoke my permission at any time. This permission remains in effect until the time I revoke it in writing.

Signature of Patient/Authorized Representative: _____ Date: _____

If other than patient, state relationship and authority to sign: _____