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

MINOR INTAKE FORM

Patient Name: ________________________ Date of Birth: ____________
Address: ________________________ City: ____________
State: ________ Zip: ________ Patient Phone (if applicable): ____________
Email address for appointment reminders (optional): ____________
Name of person completing this form: ____________
Relationship to patient: ____________

Parent 1 Information
Name: ________________________ Date of Birth: ____________
Address: ________________________ City: ____________
State: ________ Zip: ________ Phone: ____________

Parent 2 Information
Name: ________________________ Date of Birth: ____________
Address: ________________________ City: ____________
State: ________ Zip: ________ Phone: ____________

Insurance Information:
Primary Insurance: ________________ Policy Holder: ____________
Policy Holder DOB: ________ Relationship to Patient: ____________
Address: ________________ City: ________ State: ____ Zip: ________
ID #: ________________________ Group #: ____________

Secondary Insurance: ________________ Policy Holder: ____________
Policy Holder DOB: ________ Relationship to Patient: ____________
Address: ________________ City: ________ State: ____ Zip: ________
ID #: ________________________ Group #: ____________

- My signature below is confirmation that I have informed First Physical Therapy of all necessary information and have answered all questions truthfully and to the best of my ability. I authorize the therapists of First Physical Therapy to administer such treatment as is prescribed and considered therapeutically necessary on the basis of findings during the course of treatment.
- I hereby authorize my insurance benefits to be paid directly to the provider of these services. I am financially responsible for any balance due, including services that are not covered by my insurance plan. I hereby authorize the release of all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions
- First Physical Therapy Notice of Privacy Practices provides information about how we may use and disclose protected healthcare information. Copies of this notice are available in the lobby and at the front desk. I acknowledge that I have been provided access to the Notice of Privacy Practices.

________________________ ____________
Signature of Patient's Representative **Date**

How did you hear about us? Please circle: Physician, Friend, Internet, Chamber of Commerce, Advertisement, Other: ________________________

FIRST PHYSICAL THERAPY, LLC
Get your life back!

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? ______

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: ______________________