Adapt PHYSICAL THERAPY

Pre-Exam

Patient Name: _____ Date: _____

1. Are you working currently? Yes No If yes, occupation: _____
2. Have you had Physical Therapy or Chiropractic this year? _____
3. If yes, how many visits_____
4. Where is your pain/problem? _____
5. What caused your pain/problem? _____
6. Approximately what date did it start _____
7. Is it getting worse, better or staying the same?_____
8. Have you had this problem before?
9. If yes, how many times has it occurred in the last three years?_____
10. On a scale of 1 to 10, what is your worst level of pain in the past week?

1	2	3	4	5	6	7	8	9	10
Mild				Moderate				Severe	

11. Have you had any surgeries related to this problem? (please included dates)

Health History (please circle any conditions that apply)

High Blood Pressure	Alzheimer's	Huntington's	Parkinson's
Cardiovascular Disease	Immuno-suppression	Lupus	Muscular Distrophy
Obesity	Traumatic Brain Injury	Osteoarthritis	History of Cancer
Major Motor Weakness	Saddle Anesthesia	Cauda Equina Syndrome	
Diabetes Type 1	Diabetes Type 2		

Patient/Parent/Guardian Signature:_____ **Date:**_____

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Patient Registration

First Name: _____ Last Name: _____ MI: _____

Preferred Name: _____ Date of Birth: _____

Email: _____ SSN: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer/School: _____ Position: _____

Marital Status: Married Single Divorced Widowed

In case of an emergency, whom shall we contact?

Name: _____ Relationship: _____

Primary Phone: _____ Secondary Phone: _____

Designated Individuals Authorization

Please list below the name and relationship of anyone that we may release your confidential medical, personal or financial information pertaining to this office.

By singing this agreement, I hereby authorize the staff at ADAPT Physical Therapy to release any protected health information regarding my treatment, payment, or administrative operations related to my treatment at Adapt Physical Therapy to one or all of the designated parties below. I understand it is my responsibility to update the list as necessary and that the identity of the designated parties must be verified before the release of any information.

Name: _____ **Relationship**: _____

Name: _____ **Relationship**: _____

I acknowledge that the information above is correct to the best of my knowledge and the signature below allows Adapt Physical Therapy to share my personal, health and financial information only to the people that I have listed above which I can rescind permission at any time in writing.

Signature: _____ **Date:** _____

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Insurance Information

Is today's visit a result of an work or motor vehicle injury? (please circle) YES NO

If yes please list claim information below.

Who would you like us to bill for services? Self Insurance

Work Injury/ Motor Vehicle Accident Information (please circle) Work Auto

Insurance Carrier:_____ Date of Injury/Accident:_____

Adjuster Name:_____ Phone number:_____

Consent to Bill and Treat for Physical Therapy Services

I authorize ADAPT Physical Therapy to render treatment, as it/they determine necessary to me/my dependent. I understand that I will be given all pertinent information prior to the treatment being rendered. I will also be given the opportunity to ask questions and to have them answered. I understand that I may decline treatment at any time.

I authorize Adapt Physical Therapy to bill my insurance if applicable for any rendered services provided. I understand that a co-pay, co-insurance, or deductible payment may be required at the time of service. I understand that I am financially responsible for any services provided by Adapt Physical Therapy and will make appropriate payments or payment arrangements at the time of receiving a billing statement.

I acknowledge that the information and consent I have given is correct to the best of my knowledge and this signature allows Adapt Physical Therapy to use the information as needed for treatment and billing purposes.

Printed Name:_____ **Date:**_____

Signature:_____

Acknowledgment of Notice of Privacy Practices

I understand that ADAPT Physical Therapy (referred to below as "clinic") will use and disclose health information about me in the course of providing physical therapy care for me.

I understand that the clinic is permitted to use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment
- Refer to/or consult and coordinate with other health care providers in the course of treatment
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for services
- Perform various office, administrative and business functions that support the clinic's ability to provide me with appropriate are and arrange for payment

I understand that the Notice of Privacy Practices may be revised as appropriate and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request. A copy or summary of the most current version of the clinic's Notice of Privacy Practices in effect will be posted in the waiting/reception area and on the clinics website.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not to be used or disclosed, and I understand that the clinic is not required by law to agree to such requests. .

Request for Electronic Communications

I request that the following communications from the clinic be delivered to me by the provided electronic means. I understand that this form of communication may not be secure, creating a risk of improper disclosure to unauthorized individuals. I am willing to accept that risk, and will not hold the clinic responsible should such an incident occur.

Communications

_____Appointment Reminders _____Billing

Method

_____Email _____Text

Email Address_____ ___ Phone Number_____

By signing below, I agree that I have received or been offered a copy of the clinic's Privacy Practices and agree to the forms of communication above.

Patient: _____ _____ **Date**: _____

Patient Representative: _____

ADAPT PHYSICAL THERAPY

Payment and Billing Policies

Your insurance contract is between you and your carrier. Adapt Physical Therapy will bill your insurance company out of courtesy but not obligation. Adapt Physical Therapy will help to verify and assist you in understanding your benefits but it is ultimately your responsibility. By signing this form you agree not to hold Adapt Physical Therapy responsible for any misunderstanding or misrepresentation of insurance benefits. If you have questions or concerns about your insurance coverage, please call your carrier. It is the responsibility of each patient or their legal guardian to understand the terms and conditions of their insurance plan(s).

Health Insurance Claims:

We will submit claims on your behalf to your primary and secondary insurance carriers. When insurance information is unavailable or invalid at the time of the service, the patient or their legal guardian is responsible for all charges incurred. Patient or their legal guardian are required to bring a photo ID, current insurance card(s), and applicable payment to each appointment.

Medicare Claims:

ADAPT Physical Therapy accepts Medicare assignment. We will submit your claim directly to Medicare and will bill your secondary insurance if applicable after Medicare has paid their portion. You are responsible for any allowed amount that is not paid by Medicare and/or your secondary insurance.

Motor Vehicle or Workman's Compensation Claims:

ADAPT Physical Therapy will submit claims to your motor vehicle or other liability insurance carrier, if you provide accurate and complete billing information at the time of your initial visit. We will verify your claim information, as well as the availability of Personal Injury Protection (PIP) coverage on the claim. If your PIP has been exhausted or expired, we will bill your private medical insurance coverage on your behalf. If you do not have a liability insurance carrier, do not provide us with the correct and accurate information, or do not have private medical insurance you will be expected to pay for treatment at the time of service.

Responsibility for Accounts

ADAPT Physical Therapy's business office bills your health insurance plan within a few days of your visit. Health plans usually pay within 30 days. Occasionally, a health plan may request additional information before paying a claim resulting in more than 30 days to process. After your health insurance carrier has processed your claim, you will receive a billing statement from us for the remaining patient balance (co-pay, co-insurance, deductible). Your balance is due upon receipt of your statement.

It is important that you communicate with your health insurance carrier when they send you an inquiry or a dispute arises. Claims payment and/or non-payment disputes with your insurance carrier are your responsibility to resolve.

All appointments that are cancelled with less than a 24 hour notice or a no call/no show appointment may result in a $25 fee. The fee will be charge at our discretion.

Patient/Guardian signature:_____ Date:_____

Current Medications List

Name: _____ **Emergency Contact Name/Phone:** _____

Date Last Updated: _____

Medications:

Name of Medication	Strength and Frequency	Condition Medication Taken For	Physician who Prescribed Med	Notes

Allergies:

SIGNATURE _____