Consent and Statement of Financial Responsibility

1. **CONSENT FOR TREATMENT:** I consent to and authorize my physical therapist, occupational therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment. _____(initial)

2. **APPOINTMENT ATTENDANCE AGREEMENT:** I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times given one week do not automatically follow through to subsequent weeks. I agree to provide at least 24 hours notice when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment can result in a cancel/no show charge. A $20 fee will be charged for all missed or canceled appointments with less than 24 hours' notice. _____(initial)

   WORKER'S COMPENSATION PATIENTS: We appreciate your full cooperation in attending all scheduled therapy sessions. We are required to inform your Worker's Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments. It is also required that all missed visits be rescheduled.

3. **FINANCIAL POLICY:** A medical insurance policy is a contract between you and your insurance company. Coverage depends upon your insurance company and the specific plan you have chosen. 360 Physical Therapy is contracted with most insurance companies and as a service to patients, we agree to submit your claims directly to them. You may need a current physician's prescription/referral for therapy services in order to submit your claim. In order for us to submit a claim to your insurance company, we will need a copy of your insurance card. Any questions you have regarding insurance coverage or benefits should be directed to your insurance plan.

   All patient cost shares (co-payments, co-insurances and deductibles) are due at the time of treatment. For patients with co-insurance and/or deductibles, we will be asking for a good-faith payment. A good-faith payment is an estimate of what you will owe. Once the insurance carrier adjudicates the claim, we may have to bill you for any remaining balance. _____ (initial)

   Medicare Patients: If you choose to schedule therapy without a physician's prescription/referral, we MUST obtain a signed therapy plan of care from your physician within 30 days of your initial visit. Also, you must be discharged from any home health care services or agency prior to initiating outpatient therapy. Medicare will not pay for both home health and outpatient care simultaneously. _____(initial)

   Motor Vehicle: We will bill your Auto Insurance as a courtesy to you. If you do not have a direct PIP Claim, you can choose to submit your personal health insurance or pay at the time of service. We do not accept third party payers. _____(initial)

   Work Injury Claims: Medical expenses resulting from a workplace injury/disease will be submitted to the workers' compensation program on an open claim. However, if a claim is denied for any reason, the patient will be fully responsible for the total cost of the care provided._____(initial)

Cash-Pay Policy: We offer a prompt pay rate for services paid in full at the time of service. This discount is based on the administrative savings to our practice when receiving payments up front, rather than billing for services. We will not bill your insurance company for services provided under this arrangement. No forms will be produced now or in the future for you to submit claims for insurance billing._____(initial)

Rebilling Policy: It is the patient's responsibility to provide us with correct billing information. If incorrect billing information is provided and later the correct information is provided, but it is after the timely filing deadlines of your Payor, than you will be responsible for full bill._____(initial)

Unaccompanied Minors Policy: 360 Physical Therapy is authorized to provide treatment to a minor as appropriate when they arrive to an appointment unaccompanied by a parent/guardian; this may include changes in the current therapy the minor is receiving including treatments and exercises. The above financial policy is applicable to guarantor of unaccompanied minor._____(initial)

4. **INSURANCE BENEFITS:** 360 Physical Therapy as a courtesy, will attempt to verify the patient's benefits, file the claims for services provided with the insurance carrier, and notify the responsible party of their financial responsibility. The responsible party understands that at times, insurance carriers will not provide accurate benefit information, hence it is the patients responsibility to understand their own insurance benefits. The responsible party understands that the verification of benefits and authorization is done as a courtesy and not a guarantee of payment and that they are responsible for all charges not paid by the insurance company._____(initial)

Please note that refusal to sign this form does not change responsibility for payment in any way.

5. **ASSIGNMENT OF BENEFITS:** I hereby assign to 360 Physical Therapy all my rights and claims for reimbursement under my health insurance policy and such other insurance policies as I may identify in my Insurance Verification Form given to 360 Physical Therapy. I agree to provide information as needed to establish my eligibility for such benefits.

6. **CONSENT FOR EMERGENCY CONTACT INFORMATION**
Person to contact in case of an emergency:

_____	_____	_____
Name	Telephone Number	Relationship

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

_____	_____
Signature of Patient or Legally Responsible Person	Date
_____	_____
Printed Name of above	Date

Updated 09-01-2021

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

As part of my health care, 360 Physical Therapy creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and treatment to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices which provides a more complete review of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices before signing this consent.

I understand that the Notice of Privacy Practices may change at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand for **Worker's Compensation Cases**, the minimum necessary PHI/ePHI will be released to my employer, my worker's compensation insurance carrier, third party administrator, rehab nurse or nurse case manager unless otherwise restricted below.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that 360 Physical Therapy. is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices. Please complete the following that apply.

[__] I **DO NOT** authorize release of my information with the following individuals or organizations (enter names below and initial the box to left):

[__] I **DO** authorize sharing of my information with the following individuals or organizations (enter names below and initial the box to left):

[_____]Spouse/Children:_____

[_____] Other: _____

These restrictions and/or authorizations to release information will remain in effect until terminated in writing.

I acknowledge that I have received a copy of the Notice of Privacy Practices and that the full version is posted at my treatment facility and available upon request. I agree to the liability limitations explained therein.

_____ _____ _____

Signature of patient or legal representative | Date | Relationship to Patient

_____

Printed name of patient

PHYSICAL THERAPY
Celebrating 20 Years

Authorization for Text/Email Reminders

Indicate the types of messages you agree to receive by checking the boxes below. If you select more than one method for a message type, you will receive the message by all of the methods selected.

☐ Appointment reminders TEXT

☐ Appointment reminders EMAIL

☐ On Demand TEXT (allows you to correspond with your therapist for exercise instruction, recommendations and/or advice)

You acknowledge that text alerts will be sent to the MOBILE phone number you provided. Such alerts may include limited personal information and whoever has access to the mobile phone or carrier account will also be able to see this information. Once you enroll, the frequency of text alerts we send to you will vary. You will typically receive text alerts when we have information for you about your therapy prescriptions or other healthcare information. We do not impose a separate charge for text alerts; however, your mobile carrier's message and data rates may apply depending on the terms and conditions of your mobile phone contract. You are solely responsible for all message and data charges that you incur. Please contact your mobile service provider about such charges. The following carriers are supported: AT&T, Sprint, Boost, Verizon Wireless, U.S. Cellular and T-Mobile.

You may opt out of text alerts at any time. To stop receiving text alerts, reply STOP. After you submit a request to unsubscribe, you will receive one final text alert from our clinic confirming that you will no longer receive text alerts. No additional text alerts will be sent unless you re-activate your enrollment.

If you wish to receive your statements via Text or Email please check below box:

TEXT ME ☐ EMAIL ME ☐ I do not wish to receive e-statements ☐

Authorization for Credit Card on file (Patient Wallet)

I _____do hereby authorize _____to keep my credit card on file in Patient Wallet for the purpose of processing my patient cost shares. I understand that I can remove this option by informing the front desk staff at any time.

_____ _____

Patient Signature Date

MEDICAL HISTORY FORM

(Update every 6 months or when necessary)

Rate your overall health status: **Excellent Good Fair Poor** Height:__'__" Weight:_____lbs

Tobacco Use: **Y N** Year Quit:_____ Alcoholic Drinks:___Drinks per **Day Week**

Do you exercise beyond daily activities: **Y N** Days per week:____ What type of exercise:_____

Any major life changes in the past year: **Y N** Explain:_____

Do you have any allergies: **Y N** Explain:_____

Please check if you have ever had:

□Arthritis □Broken bones
□Osteoporosis □Blood disorders
□Heart problem □High blood pressure
□Lung problem □Stroke
□Diabetes □Hypoglycemia (low blood sugar)
□Head injury □Multiple Sclerosis
□Muscular dystrophy □Parkinson's disease
□Seizures/epilepsy □Allergies
□Thyroid problem □Developmental (growth) problem
□Cancer □Tuberculosis
□Hepatitis □Kidney problems
□Repeated infections □Ulcers/stomach problems
□Skin diseases □Depression
□Pacemaker □Fibromyalgia
□Hernia □Migraines
□Concussion □Asthma
□AIDS/HIV □Anemia
□Appendicitis □Circulation/vascular problems
□Other_____

Within the past year have you had any of the following?

□Chest pain □Difficulty sleeping
□Heart palpitations □Loss of appetite
□Cough □Nausea/vomiting
□Hoarseness □Difficulty swallowing
□Shortness of breath □Bowel problems
□Dizziness or blackouts □Weight loss/gain
□Coordination problems □Urinary problems
□Headaches □Weakness in arms or legs
□Fever/chills/sweats □Loss of balance
□Difficulty walking □Hearing problems
□Joint pain or swelling □Vision problems
□Pain at night □ Other _____

Men: Prostate disease □Yes □No

Women: □Pelvic inflammatory disease □Endometriosis
□Trouble with your periods □Complicated pregnancy
□Currently pregnant

Primary Care Physician (If different than referring Doctor): _____

Employment Status: **Full Time Part Time Unemployed Retired**

Are there any customs, religious beliefs or wishes you would like your 360 PT to be aware of?

Yes / No If Yes, please explain:_____

With whom do you live? **Alone Spouse Child(ren) Care attendant Parent(s) Other**

Does your home have**: Stairs Ramps Uneven Terrain Assistive Devices Elevator Other Obstacles**

Do you use: **Glasses Cane 2 Wheel walker 4 Wheel walker Motorized wheelchair**

Manual wheelchair Crutches Hearing aids Other:_____

Medications	**Surgeries**
_____	_____
_____	_____

EVALUATION FORM

(For each new Case)

In order to evaluate your condition, please complete entire form as accurate as possible for ***THIS INJURY/EPISODE***.

Patient Name:_____Date:___/___/____

Has there been ANY changes to your medical history/medications since your last injury/episode here? Y N

Are you seeing anyone else for this problem:_____

Was this injury/episode cause by a motor vehicle accident? **Y N** Date of Accident: ___/___/____

Is this injury/episode related to a work injury: **Y N** Date of Injury:___/___/____

Current work status: **FT PT UNEMPLOYED DISABLED** Work Restrictions:_____

Have you fallen in the past 12 months: **Y N** How many times:_____ Which is your dominant hand: **R L**

Do you have difficulty walking/balance? **Y N** Any current restrictions:_____
What diagnostic tests have been performed for this problem? **X-ray CT scan MRI Other**

1	Where is your pain/problem?	
2	What caused your pain/problem?	
3	Have you had this same pain/problem before?	**N Y (Explain)**
4	What makes your pain/problem better?	
5	What makes your pain/problem worse?	
6	When did your pain/problem begin?	
8	On the scale, circle your average daily pain.	MILD MODERATE SEVERE 0….1….2….3….4….5….6….7….8….9….10

Please list **3 activities** in your life that are difficult to perform or you are having the most difficulty performing as a result of your injury or problem. **Score each activity on a scale of 0** (unable to perform activity) **to 10** (able to perform activity the same as before injury).

Activity Description		Score 0-10
1		
2		
3		