THINK PHYSICAL THERAPY

PATIENT INFORMATION

Please present your insurance card(s) for copying.

Patient Name:	**Sex:**	**Date of Birth:**	**Age:**
Social Security Number:	**Employment Status:** Emp Unemp Retired Student	**Marital Status:** Single Married Other	
Address: City State Zip			
Home Phone:	**Cell Phone:**	**Work Phone:**	
Employer:	**Referring MD:**		
Attorney:	**Attorney Address:**	**Attorney Phone:**	
Financial Party:(if other than patient)	**Relationship:**	**Social Security Number:**	**Date of Birth:**
Home Phone:	**Work Phone:**	**Employer:**	
Emergency Contact:	**Relationship:**	**Home Phone:**	
Address:		**Work Phone:**	
Current Injury:	**Date of Onset:**		

Medical History: Have had any of the following: (circle yes or no)

High Blood Pressure	**yes no**	**Pregnancy**	**yes no**	**Metal Implants**	**yes no**
Heart Attack	**yes no**	**Allergies**	**yes no**	**Previous Surgery**	**yes no**
Heart Disease	**yes no**	**Hernia**	**yes no**	**Fever**	**yes no**
Pacemaker	**yes no**	**Seizures**	**yes no**	**Cancer**	**yes no**
Headaches	**yes no**	**Sensitive to heat or ice**	**yes no**	**Nervous Disorders**	**yes no**
Kidney Problems	**yes no**	**Night Pain**	**yes no**	**Diabetes**	**yes no**

Please list current medications:

Please give a brief explanation and dates for any area marked yes:

The above information is correct to the best of my knowledge. In signing below, I agree to be treated by the staff of Think Physical Therapy. I authorize the release of medical information to my insurance company necessary to process claims for services rendered by Think Physical Therapy. I authorize payment of medical benefits directly to Think Physical Therapy. I understand that I am financially responsible to Think Physical Therapy for all unpaid balances.

Signed: _____ Date: _____

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

THINK PHYSICAL THERAPY'S LEGAL DUTY

Think Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Think Physical Therapy uses your patient health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Think Physical Therapy may also use or disclose your personal health information without prior authorization for emergencies, research studies and auditing purposes. We also provide information when required by law. In any other situation, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Think Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except where specifically authorized by you, when required by law or in emergency circumstances. Think Physical Therapy will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that we may have violated your rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Privacy Officer at the address listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. For further information on our health information practices or if you have a complete, please contact the following person:

Think Physical Therapy
Attn: Randy Pinkerton, Privacy Officer

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Think Physical Therapy's Notice of Information Practices. I understand that Think Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Think Physical Therapy will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Think Physical Therapy's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____

Patient Name

_____

Signature

_____

Date

OFFICE PAYMENT POLICY - THINK PHYSICAL THERAPY

It is the policy of Think Physical Therapy that payment is due and to be made at the time of service is rendered unless other financial arrangements are made in advance. Our physical therapy charges are based on the procedures and modalities used and the length of your treatment. Treatments are usually 30, 45 or 60 minutes long. Charges range from $25 to $40 per 15-minute increments, depending upon the type of treatment being performed. If you are covered by health insurance with physical therapy benefits, we will be happy to bill your insurance. Please provide your insurance information to the office manager and we will verify your coverage as a courtesy. Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by a physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100% responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment. Therefore, we highly recommend you also contact your insurance carrier and check into your coverage for physical therapy. Do not assume that you will not owe anything if you have more than one insurance policy. If you have any questions regarding your insurance coverage or need special arrangements to be made, please discuss this with the office manger before starting your treatments.

Please initial your payment method and sign below that you have read, understand, and agree with all of the information on this page:

_____ 1. PRIVATE HEALTH INSURANCE (PPO): Some insurance plans require authorization or a referral from your primary physician. Most insurance plans have a patient responsibility of a deductible (amount paid by the patient before the insurance policy begins payment for services) and either a copay (a set dollar amount per visit) or coinsurance (a percent of the allowed charges). Deductibles and copays are due at the time of service. We will bill you for coinsurance or other payment due after we have been paid by your insurance or notified of their denial for payment.

_____ 2. HMO Insurance: Authorization from your insurance must be obtained prior to treatment. Any copay or coinsurance is due at the time of treatment. If your HMO plan also has a Point of Service option you are using, please be sure you understand the difference in your Point of Service coverage verses your HMO coverage.

_____ 3. MEDICARE: Think Physical Therapy. is a certified Medicare provider. Medicare has an annual deductible of $100.00 for PT and Speech. Medi-Gap insurance covers the patient portion due until your Medicare benefits are exhausted. Some insurance plans that are secondary to Medicare cover the patient portion due and services after Medicare benefits are exhausted, but not always. Please verify all of your insurance benefits and be sure you understand your insurance coverage.

_____ 4. NO INSURANCE: If you do not have insurance and we do not have administrative costs for your services, you may be eligible for an administrative discount. Please notify the office staff that you do not have insurance so that a payment plan can be discussed.

_____ 5. OTHER: Please list the other type of payment: _____

_____ 6. WORKER'S COMPENSATION CLAIMS: Authorization from your insurance adjuster is required before you can begin treatment. Please provide the office manager with the name and phone number of your adjuster, the date of your injury and your claim number, and any other pertinent information.

_____ 7. THIRD PARTY PAYERS AND AUTO LIENS: We will bill your insurance, however, third party payments will be sent to you for our services, not to us. You are responsible for payment of all service provided. Please be sure to contact this office when your case is settled to ensure your account has been paid. ATTENTION AUTO ACCIDENT VICTIMS AND WORKER'S COMPENSATION INJURY PATIENTS: Please sign a release of information authorizing us to discuss your treatment with your attorney. If you retain an attorney during or after your course of treatment, please inform the office manager of this change. If you plan for your attorney to settle your account with us, you must sign a LIEN agreement. A statement of account will be sent to you or your attorney on a monthly basis until the account is paid. I have reviewed this office policies statement and discussed it with the clinical office manager. All my questions have been answered to my satisfaction and I understand all the information that has been explained to me.

Signature: _____ Date: _____

Think Physical Therapy Referral Information

To improve our customer service, cut down on the amount of paper used, and improve our quality of care, we would appreciate it if you would answer a couple of questions.

1. Please provide us with your email address. You will receive contact information, a newsletter, and information regarding your bill. **(Private health information is not sent via the Internet.)**

First Name : _____ Last Name :_____

Email Address : _____

2. How did you find out about Think Physical Therapy?
(Please check all that apply)

- ☐ My doctor referred me to your clinic.
- ☐ I found out about your clinic from a friend.
- ☐ I was a previous patient.
- ☐ I heard about your services from one of your physical therapists.
- ☐ I learned of your services from your email newsletter.
- ☐ I learned of your clinics and services from the Internet.
- ☐ Other _____
- ☐ Don't send me the newsletter

You will be receiving an email from us soon.

Best Regards,

Think Physical Therapy

THINK PHYSICAL THERAPY CANCELLATION POLICY

SHOULD ANY PATIENT NOT BE ABLE TO MAKE A PREVIOUSLY SCHEDULED APPOINTMENT, A 24-HOUR NOTICE OF CANCELLATION MUST BE GIVEN BY PHONE OR IN PERSON TO THE OFFICE MANAGER. IF THERE IS NOT NOTICE OF CANCELLATION 24 HOURS BEFORE THE SCHEDULED APPOINTMENT, A $20 CHARGE WILL BE BILLED DIRECTLY TO THE PATIENT FOR EACH CANCELLATION. WE AT THINK PHYSICAL THERAPY WANT TO PROVIDE THE BEST POSSIBLE CARE FOR OUR PATIENTS AND ATTENDING YOUR SCHEDULED APPOINTMENTS IS THE NECESSARY PART OF THE TREATMENT PROCESS. IF YOU HAVE ANY FURTHER QUESTIONS PLEASE DO NOT HESITATE TO ASK THE OFFICE MANAGER OR YOUR THERAPIST.

BY SIGNING BELOW, YOU ACKNOWLEDGE THAT YOU HAVE READ, UNDERSTOOD, AND AGREE WITH OUR CANCELLATION POLICY.

SIGNATURE _____ DATE _____