

Patient Information



Patient Name _____ Male ___ Female ___
 Married Divorced Widowed Single

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ S.S. Number _____

Date of Birth _____ Age _____ Primary Insured's Date of Birth _____

Employer _____ Employer Phone _____ Occupation _____

Date of Injury _____ Date of Surgery _____ **Email** _____

How did you hear about us? (check all that apply)

- Physician Directed Me Physician Let Me Choose Radio Sign Family/Friend
 Yellow Pages Location Referred Myself Other _____

Referring Physicians Name _____

Is there another physician you would like us to keep updated? _____

Insurance Information

I hereby consent to such physical therapy and occupational therapy procedures as may be rendered by Idaho Physical Therapy. There is also consent for authorization for all insurance benefits to be paid directly to Idaho Physical Therapy, and assumption of all financial responsibility for the balance of charges not included in the insurance coverage.

Patient Signature _____ Date _____
(Parent signature if 18 or under)

Medicare and Medicaid Patient Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Idaho Physical Therapy for any service furnished me by Idaho Physical Therapy. I authorize any holder of medial information about me to release to the Centers of Medicare and Medicaid Services, formally the Health Care Financing Administration and its agents any information needed to determine there benefits or the benefits payable for related services.

Patient Signature: _____ Date _____

***Patient Medical History
And Personal Fitness Questionnaire***

Personal History

Circle each as it applies to you. Have you ever had:

Condition

Cardiac Pacemaker	Yes	No
Heart attack	Yes	No
Angina	Yes	No
Emphysema	Yes	No
High Blood Pressure	Yes	No
Diabetes	Yes	No
Stroke	Yes	No
Severe Illness	Yes	No
Blackouts	Yes	No
Gout	Yes	No
Nervousness	Yes	No
Joint Problems	Yes	No
Sleep Interference	Yes	No
Chest Pain	Yes	No
Cancer	Yes	No

Condition

Peripheral Vascular	Yes	No
Convulsions	Yes	No
Paralysis	Yes	No
Leg Cramps	Yes	No
Headache	Yes	No
Depression	Yes	No
Shortness of Breath	Yes	No
Arm Pain	Yes	No
Low Blood Pressure	Yes	No
Indigestion/Ulcers	Yes	No
T.B.	Yes	No
Asthma	Yes	No
Hernia	Yes	No
Back Pain	Yes	No
Allergy	Yes	No

For any condition in which a “Yes” was indicated please give dates and any details:

Any other medical problems? If so, please describe:

List your current medications: _____

Family History: Circle each as it applies to a blood relative:

Heart Attack	Yes	No	Tuberculosis	Yes	No
High Blood Pressure	Yes	No	Diabetes	Yes	No
Circulatory Disorder	Yes	No	Stroke	Yes	No
Heart Disease	Yes	No	Asthma	Yes	No

Height _____ Weight _____lbs.

Do you consume alcohol? Yes No If yes, how much? ___ drinks per week/month(circle)

Do you smoke? Yes No If yes, how much? ___ packs per day/week(circle)

I certify to the best of my knowledge the above answers are true and correct.

Patient Signature _____ Date _____



Notice of Privacy Consent Form

By signing this form, you are giving consent to Idaho Physical Therapy to use and disclose your protected health information for the purposes of treatment, payment and health care operations. We have developed a Notice of Privacy Practices that provides more detailed information about how, and under what circumstances, we may use and disclose that information. We will be happy to provide you our Notice of Privacy Practices for you to review prior to signing this form.

You have the right to request restrictions on how we may use and disclose your protected health information, however, please be aware we are not legally bound to comply. Should Idaho Physical Therapy make such an agreement regarding your requested restrictions, we are then bound by that agreement. If at any time you desire to change that agreement, written consent is required.

Our Notice of Privacy Practices may be changed periodically. In that even, you may obtain a revised copy by contacting our office.

Name (print) _____

Signature _____

Date _____



Payment Policy

1. All patient co-payments are due in full at time of service.
2. Idaho Physical Therapy will gladly bill your insurance company for you according to the services and procedures performed during your visits, however, please remember that it is your responsibility to know exactly what your insurance plan covers. Some insurances have limits, either monetary or numerical, as to how much outpatient physical therapy they will cover. It is important to understand your individual plan.
3. Patients who are not covered by an insurance company must pay in full at the time of service.
4. All charges become due and payable upon 30 days after final billing to insurance. Any balance remaining after this point will be assessed an annual finance fee of 24%, which will be billed at a periodical rate of 2% per month.
5. We will accept, and recommend, any partial payments you may wish to pay beyond your co-payments at the time of service. This will allow you to make frequent smaller payments and will lower the final balance that may exist when you have completed your treatments, and insurance responsibility is complete.
6. Please contact Idaho Physical Therapy within 30 days of the first billing for any disputed accounts.
7. If payment arrangements are necessary, we will be happy to work out a payment schedule with you to clear your account. Any account left unpaid after 60 days may be referred for collection or legal proceedings.

Idaho Physical Therapy will submit bills to your insurance company for services rendered. After this the bill is considered your responsibility, regardless of whether your insurance company makes payment.

If you have any questions regarding these policies please contact us before services begin.

I have read and understand the above payment policy and agree to all terms stated above:

Guarantor or Patient Signature _____

Date _____



Motor Vehicle Accident Policy

(Please note only applies if therapy is required because of a motor vehicle accident)

Due to recent delayed payments from third party insurances and lengthy legal settlements, Idaho Physical Therapy will no longer accept third party billing and will now require payment as treatment is rendered. If **YOUR** health insurance or auto insurance will not pay during your time of treatment, you will be required to pay 50% of your bill during treatment. Upon your discharge, we require you to pay the remaining balance within 4 months. If arrangements have not been made with Idaho Physical Therapy billing department, at 318-0600, and your bill is not paid within the 4 month period, your account will be referred to an outside collection agency. This will apply even if you have an attorney.

By signing this policy you are agreeing to these conditions.

Patient Signature _____

Date _____

Cancellation and “No-Show” Policy

Please carefully review the following guidelines concerning your scheduled visits here at Idaho Physical Therapy. The following information has direct implications on the success of your treatment.

- A 24 hour notice either by phone or personal visit is expected when canceling a scheduled appointment.
- Calls which are left on the message machine after hours are also acceptable means to cancel appointments as long as they are at least 24 hours in advance.
- You will be charged \$10 for each scheduled appointment missed if cancellation policy is not followed correctly. **This charge is to be paid by you, not your insurance company**, at the next scheduled visit.
- A charge of \$15 will be assessed to persons who simply fail to show up and who do not call at any time to inform the office of their inability to attend their appointment.

Please understand your pain may increase or decrease as your course of treatment progresses. This is not a sufficient reason alone to miss any scheduled appointment. If you are feeling worse or better after treatment please continue to attend your appointments as this will give our therapist a chance to address your progress.

Patients are to avoid bringing their small children to their scheduled appointments. We realize, however, this is not always possible. In the event that your children must be with you at your appointment, we ask that they be supervised by someone else who is with you and that they remain in our waiting area at all times. This is both for their safety as well as the other patients privacy.

Thank you for your cooperation. Please address any questions/concerns you have with our front desk personnel.

Patient Signature _____

Date _____



To All Medicare Patients:

Welcome to Idaho Physical Therapy. We will do everything possible to provide the best care during your rehabilitation process. In addition to providing quality rehabilitation services, we want to assist you in understanding your Medicare policy and our billing procedures.

In 2008, Medicare will pay 80% of physical therapy charges after your deductible has been met. Beginning July 1, 2008, Medicare is reinstating a cap on physical therapy charges in the amount of \$1810.00. At this rate, our therapists will be able to see Medicare patients approximately 21 times until the maximum is reached. Additionally, we will bill any secondary insurance you may have. As these policies vary greatly, we advise you to contact that particular insurance company to find out exactly what they will pay.

Patient Signature _____

Date _____

Thank you for your time and cooperation, and feel free to ask any questions you may have at any time.