

## Patient Information



Patient Name \_\_\_\_\_  Male  Female  
 Married  Divorced  Widowed  Single

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (home) \_\_\_\_\_ (cell) \_\_\_\_\_ S.S. Number \_\_\_\_\_

DOB \_\_\_\_\_ Age \_\_\_\_\_ Primary Insured's DOB \_\_\_\_\_

Employer \_\_\_\_\_ Employer Phone \_\_\_\_\_

Occupation \_\_\_\_\_ Email \_\_\_\_\_

Date of Injury \_\_\_\_\_ Date of Surgery \_\_\_\_\_

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

Physician directed me  Physician let me choose  Family/friend  Website  
 Location/drove by  Former patient here  Facebook/Twitter  Postcard

Phonebook ad (please list which book) \_\_\_\_\_

Other (please explain) \_\_\_\_\_

Referring Physician's 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 Patient is under 18) \_\_\_\_\_

### **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 medical 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 the benefits or the benefits payable for related services.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

# Patient Medical History Questionnaire



**Personal History** Circle "Yes" or "No" as applicable. Have you ever had:

Cardiac Pacemaker	Yes	No	Liver Disease	Yes	No
Heart Attack	Yes	No	Kidney Disease	Yes	No
Angina/Chest Pains	Yes	No	Paralysis	Yes	No
Emphysema	Yes	No	Leg Cramps	Yes	No
High Blood Pressure	Yes	No	Headache	Yes	No
Diabetes	Yes	No	Depression	Yes	No
Stroke	Yes	No	Shortness of Breath	Yes	No
Blurred/Double Vision	Yes	No	Arm Pain	Yes	No
Blackouts	Yes	No	Low Blood Pressure	Yes	No
Gout	Yes	No	Indigestion/Ulcers	Yes	No
Nervousness/Anxiety	Yes	No	Tuberculosis	Yes	No
Joint Problems	Yes	No	Asthma	Yes	No
Pain that wakes you up	Yes	No	Hernia	Yes	No
Unexplained Weight Loss	Yes	No	Neuropathy	Yes	No
Cancer	Yes	No	Allergy	Yes	No
Blood Clot	Yes	No	Dizziness	Yes	No
Swelling of Legs/Feet	Yes	No	Numbness/Tingling of		
Chronic/Frequent Cough	Yes	No	Extremities	Yes	No
Seizures	Yes	No	Change in Bowel/Bladder		
Pain not affected by activity or position	Yes	No	Control	Yes	No

For all conditions in which a "Yes" was indicated above, please give dates and details below: \_\_\_\_\_

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Do you have any other medical problems which are not listed here (including any recent surgeries)? \_\_\_\_\_

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List current medications and dosages (include over-the-counter meds & vitamins): \_\_\_\_\_

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Your Height \_\_\_\_\_ Your Weight \_\_\_\_\_

Do you consume alcohol? Yes No If "Yes," how many drinks per week/month? \_\_\_\_\_

Do you smoke? Yes No If "Yes," how many packs per week/month? \_\_\_\_\_

I certify to the best of my knowledge that 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 event, you may obtain a revised copy by contacting our office.

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Patient Name (please print)

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Patient Signature

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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. All charges become due and payable upon 30 days after final billing to insurance.
4. We will accept, and recommend, any partial payments you may wish to make beyond your co-payments at the time of service. This will allow you to make more frequent, smaller payments and will lower the final balance that may exist when you have finished your treatments and insurance responsibility is complete.
5. Payments may be made via debit/credit cards, cash, or personal checks. All returned checks will be charged a \$5 return fee added the patient's account.
6. Please contact Idaho Physical Therapy within 30 days of the first billing for any disputed amounts.
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 unless previous arrangements have been established.
8. 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.
9. 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.

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Guarantor or Patient Name (please print)

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Guarantor or Patient Signature

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Date



## ***ATTENDANCE 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 an 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 this cancellation policy is not followed correctly.
- 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.
- This charge is to be paid by you, not your insurance company, at the next scheduled visit.
- Patients will be given one "grace" no show/cancellation, after which fees will be charged.
- Patients whose accounts have been on "hold" (meaning you are waiting to come back to therapy for any reason) for more than 30 days will be discharged.

Please understand your pain may increase or decrease as your 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 appointments. We realize, however, that 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.

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Patient Name (please print)

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Patient Signature

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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 rehabilitative services, we want to assist you in understanding your Medicare policy and our billing procedures.

Medicare pays 80% of physical therapy charges after your deductible has been met. Since July 1, 2008, Medicare has reinstated 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.

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

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Patient Name (please print)

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Patient Signature

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Date



## ***MOTOR VEHICLE ACCIDENT POLICY***

*(Note: This only applies if therapy is required because of a motor vehicle accident.)*

Due to delayed payments from third party insurances and lengthy legal settlements, Idaho Physical Therapy does not accept third party billing and requires 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 the Idaho Physical Therapy billing department (the contact number is 318-0600) and your bill is not paid within the 4 month period, your account will be referred to an outside collection agency unless previous arrangements have been established. This will apply even if you have an attorney.

By signing this policy, you are agreeing to these conditions.

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Patient Name (please print)

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Patient Signature

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Date