PATIENT INFORMATION

Name:_____ **Date:**_____

SS# (insurance requirement):_____

Date of Birth:_____ **Age:**_____

Driver's License:_____

Marital Status:___Single ___Married ___Divorced ___Widowed

Mailing Address:_____ **City:**_____ **Zip:**_____

Physical Address (if different):_____**City:**_____**Zip:**_____

Home Phone:_____ **Cell:**_____ **Work:**_____

Email Address: _____

Employer:_____

May we leave a detailed message at home? _____Yes ___No **Cell** ____Yes ___No

Would you like to receive appointment reminders? ___No ___Yes, by (choose 1):

____Text ____Phone ____E-mail

Parent/Spouse Name:_____

DOB & SS#:_____

Parent/Spouse Employer:_____

Emergency Contact (someone not living with you)

Name:_____ **Relation:**_____

Home Phone:_____ **Cell:**_____ **Work:**_____

Medicare Patients Only

Have you had any Physical Therapy or Home Health in the past year?_____. If yes, when and where?_____

Are you currently receiving Home Health (bathing, aide help, therapy, nurse visit)?_____ If you are currently receiving Home Health or have received Home Health in the past 3 months please **STOP HERE** and speak to or call the receptionist at (806) 467-8181.

INFORMED CONSENT FOR TREATMENT

Complete if Over the Age of 18 Years Old

The undersigned, being over the age of eighteen (18) years and being under no disability or prohibition that would in any way prevent or affect the Consent and Release, does hereby represent that, I _____(patient), consent to rehabilitation treatment as prescribed by my provider.

Complete if the Patient is Minor or When the Adult Patient is Not Competent

In the treatment of _____(minor/adult patient), I the patient representative, of said minor/adult consent to rehabilitation treatment as prescribed by minor's/adult's provider. My relationship to the patient is (i.e. parent, son, daughter, etc)_____.

I certify that the information I have provided is complete and true to the best of my knowledge.

I give my authorization for treatment records to be released to the responsible payor for reimbursement consideration, or medical facility necessary for treatment or further care. Additionally, I request that any medical records requested by this facility, necessary for treatment or further care, be forwarded to this facility upon its request.

I understand that I am financially responsible for all charges whether or not paid for by said insurance (i.e. deductible amounts, co-insurance, co-pay, or any other balance not paid by my insurance). If this account is assigned to an attorney for collection and/or suit, the facility shall be entitled to reasonable attorney's fees and costs of collection.

I request that payment of authorized benefits be made on my behalf to this facility. I assign the benefits payable to which I am entitled to this facility for services rendered. This assignment will remain in effect until revoked by me in writing. A photocopy and/or facsimile of this assignment is to be considered as valid as an original.

I understand I may request and be provided a copy of Notice of Privacy Practices for TOTAL PHYSICAL THERAPY (TPT) and that TPT reserves the right to modify the privacy practices outlined in the notice. I have been issued a copy of TPT's Financial Policy and understand the terms of such policy and agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. This agreement applies to previous, current or future transactions.

I have read the aforementioned and I understand. Any questions that have arisen or occurred to me have been answered to my satisfaction.

_____ _____

Patient or Patient Representative Signature Date

FINANCIAL POLICY: PLEASE READ & PROVIDE INFORMATION AT THE BOTTOM OF FORM

You may request a copy of this policy agreement with our front office.

This is an agreement between **Total Enhancement Therapy, LLC dba Total Physical Therapy,** as creditor and the Patient/Debtor named on this form.

In this agreement the words "you", "your", and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "ours" refer to **Total Enhancement Therapy, LLC dba Total Physical Therapy.**

By executing this agreement, you are agreeing to pay for all services that your insurance carrier recognizes as patient responsibility.

Insurance: On your behalf we will contact your insurance company to verify coverage and benefits regarding out-patient physical therapy per your policy. Insurance is a contract between you and your insurance company. An insurance card must be made available to us before you are seen as a patient. Even though we may estimate what your insurance will pay, it is the Insurance Company that makes the final determination of your eligibility and responsibility. You are responsible for any amount as determined by your insurance carrier such as co-pays, coinsurance at the time of service which may be paid by cash, check or credit card (MasterCard or Visa).

Required Payments: Any co-payments required by an insurance company must be paid at the time of service. This is required by your insurance. Coinsurance (i.e. % insurance does not cover) will be handled on a case by case basis.

Billing for Patient Responsibility: Our policy is to bill all patients throughout duration of treatment. In the event that you are billed for services, payment is expected timely, unless prior arrangements have been made.

Payments: Unless we approve other arrangements, the balance of your statement is due and payable when the statement is issued, and is past due if not paid within 21 days. No more than 3 monthly statements will be sent if payment is not received.

Past due accounts: If your account becomes past due (over 90 days), we will take necessary steps to collect this debt. If we have to refer your debt to a collection agency, you agree to pay additional collection costs incurred from delinquency fees, address searches, credit reports or attorney fees which can possibly equal 50% of the balance due. We may also take the claim to Small Claims Court. You agree to pay any court fees incurred in trying to collect the past due balance. We have the option to report your account status to any credit reporting agency such as credit bureaus.

Payment if you have no insurance:
You choose to pay cash, check or credit card (MasterCard, Visa, or Discover) on the day that treatment is rendered. Payment plans may be available on a case-by-case basis. Please let us know today if you will be needing arrangements for a payment plan

Returned checks: There is $25.00 fee for any checks returned by the bank. We prefer payment in cash on accounts with history of a returned check.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if you're past due status is reported to a credit reporting agency, the fact that you receive treatment at our office may become a matter of public record.

Workers' Compensation: We require authorization by your workers' compensation carrier (not employer) prior to your initial visit. If your claim is denied, you will be responsible for payment in full. If your case is in dispute, we will require payment at the time of service until we receive information stating your employer's carrier will pay for services. Please remember that in order to receive your Work Comp benefits, you must keep your appointments.

Personal Injury (motor vehicle accident: We require payment of our private pay rate prior to each visit/treatment and we will gladly provide you with statements demonstrating your out-of-pocket expenses to submit to your attorney for settlement purposes. The remaining balance will be submitted to your attorney for payment upon settlement. Payment of all incurred charges/total bill ultimately remains your responsibility. You also acknowledge that your signature also serves as an Assignment of Health Care Benefits and you authorize your attorney or liability carrier to pay those lien amounts directly to **Total Physical Therapy** out of any settlement proceeds without further authorization from you.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent changes.

Medical Records: I hereby understand that I will be assessed of fee of $25.00 (for first 20 pages and $.15 for each additional page) for preparation of my medical records.

Effective date: Your signature in the Patient Information becomes the effective date and you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. This agreement applies to previous, current or future transactions.

Missed appointments: To serve our clients best, should you cancel or reschedule an appointment, we request at least 24-hour notice. If an appointment must be cancelled with less than 24-hour notice, you can be subject to a $25 fee. Should you feel that regular attendance is conflicting with your work/life schedule, please be advised that we offer appointments on the same day as requested.

Secure Payment for Your Convenience

To provide you with seamless and efficient experience, we utilize an industry-leading **secure, encrypted** payment processing system to keep a credit card on file. This allows us to streamline your visits and save you time at check-in by automatically processing balances related to your care and purchases. Your financial security is important to us. Our office does not retain any paper copies of your credit card information. These documents are shredded following encryption within our billing software.

By providing your information below, you authorize Total Physical Therapy to securely store your cardholder information and charge this payment method for services rendered including co-payments, coinsurance, outstanding balances, retail purchases, and fees associated with appointments not canceled within our policy timeframe (within 24 hours of appointment). Receipt of payment for services or purchases can be emailed or printed at your request.

You may revoke or update this agreement at any time by notifying our office.

Credit Card Authorization Agreement

Card Holder Name: _____

Credit Card Number: _____

Expiration Date: _____ CVV (3 digit code): _____

I have read through TPT Financial Policy and agree to the terms and conditions.

Signature: _____ **Date**:_____

Name:_____ Referring Provider:_____ Date_____

When did your symptoms/problems begin? _____

Briefly describe history of your problem(s) for which you are seeking guidance:

_____

_____

_____

_____

_____

If applicable please **rate your pain** on a scale from 0-10 (where: 0 = no pain, 10 = Emergency Room)

At its **Worst**: ____ /10, **Current**: _____ /10, At its **Best**: _____ /10

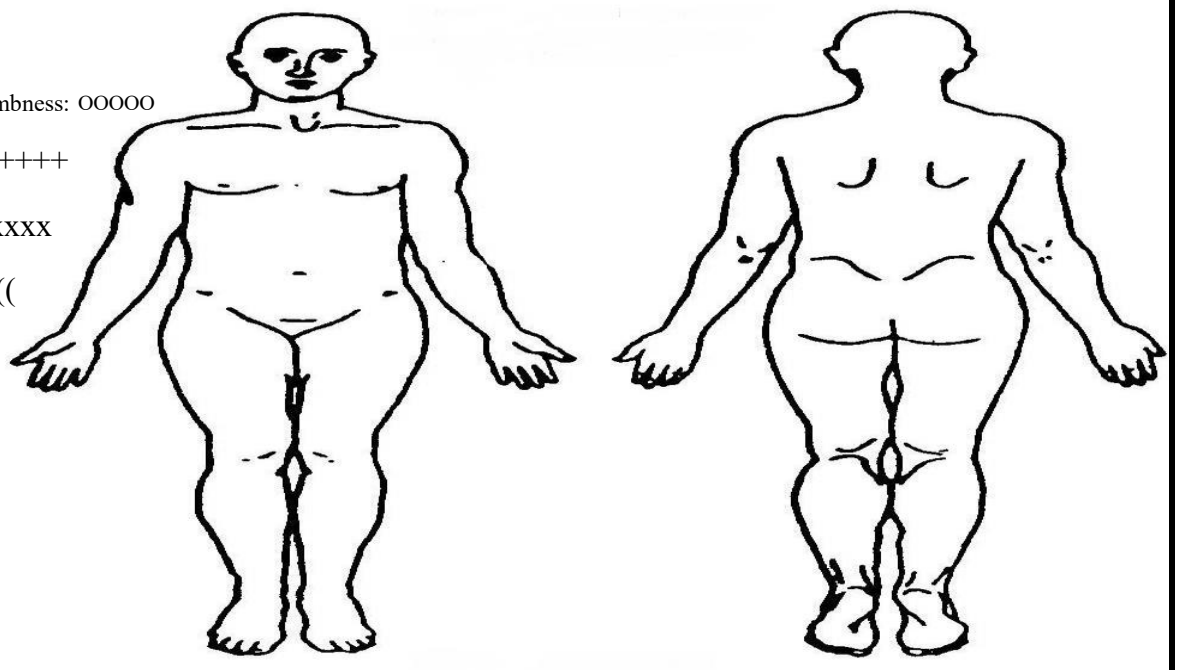
Please mark the location and type of your pain using the following key:

Pins/Needles/Numbness: OOOOO

Stabbing Pain: +++++

Burning Pain: XXXXX

Aching pain: (((((



Please list your **occupation/job title** (if applicable) _____

Working Status: ☐Full time ☐Part time ☐Disabled ☐Not currently working

Have you **fallen** in the past 12 months? ☐No falls ☐1-3 falls ☐ More than 3 falls

Past Medical History: Please check if you have or had any of the following (check all that apply)

☐ No Medical History	☐ Diabetes	☐ Genetic Disease	☐ Pacemaker
☐ AIDS	☐ Emphysema	☐ Kidney Disease	☐ Parkinson's Disease
☐ Asthma	☐ Epilepsy/Seizures	☐ Liver Disease	☐ Prostate Disease
☐ Arthritis	☐ Glaucoma	☐ Low Blood Pressure	☐ Repeated Infections
☐ Blood Disorders	☐ Heart Attack/Heart	☐ Lung Disorder	☐ Skin Disorders
☐ Circulation Problems	☐ Hepatitis	☐ Lyme's Disease	☐ Stroke
☐ Cancer	☐ Head Injury/concussion	☐ Macular Degeneration	☐ Thyroid Disorder
☐ Cystic Fibrosis	☐ High Blood Pressure	☐ Multiple Sclerosis	☐ _____
☐ Depression	☐ High Cholesterol	☐ Osteoporosis	☐ _____

Past Surgical History: ☐ No surgeries to date (Please use back of page for additional space)

1. _____ Date: _____ 2. _____ Date: _____

3. _____ Date: _____ 4. _____ Date: _____

Do you use any forms of tobacco? ☐Yes ☐No

Please list any **allergies**: ☐No known allergies ☐_____

WEIGHT: _____ pounds **HEIGHT**: _____

Please provide a goal(s) that you hope physical therapy can meet for you:

_____

_____

_____

Please tell us how you discovered Total Physical Therapy (check all that applies):

☐ Physician suggested Total Physical Therapy (TPT).	☐ I have family currently or previously seen at TPT.
☐ Physician gave me a list to choose from. I chose you.	☐ A friend recommended you. If so who _____
☐ Someone in my physician's office recommended you.	☐ Internet search or social media.
☐ Your location is best for me.	☐ Telephone book
☐ Decision based on insurance company.	☐ Handouts/Flyers/Newsletters/Community Advertisements
☐ I have previously been a patient at TPT.	☐ Anything else:_____