SILVER CREEK PHYSICAL THERAPY

PATIENT INFORMATION: *Please present insurance cards to receptionist*

First Name:_____ Last Name:_____ M.I.:_____

Date of Birth: _____-_____-_____ Sex: □ Male □ Female

Address:_____ APT:_____

City:_____ State:_____ Zip Code:_____

Cell Phone #: (_____) _____-_____ Home #: (_____) _____-_____

Email Address: _____ OK to communicate via email? □ Yes □ No

How would you like your appointment reminder? □ Phone □ Text □ Email □ None

Emergency Contact:_____Phone: (_____) _____-_____

INSURANCE: *Please fill out only if you're NOT the subscriber*

Name of Insured: _____ Date of Birth:_____-_____-_____

Address (if different):_____ APT:_____

City:_____ State:_____ Zip Code:_____

Relationship to insured: □ Self □ Spouse □ Child □ Other

IS YOUR CONDITION: □ Work related □ Auto accident DATE OF INJURY: _____-_____-_____

HEALTH HISTORY: *Feel free to provide separate sheet if needed*

Additional current medical problems:_____

Have you been admitted to the hospital or undergone any surgical procedures in the last 5 years? □ Yes □ No

If yes, what was the condition?_____

Is this condition the reason you were referred to Physical Therapy? □ Yes □ No

Have you received any physical therapy treatments during the past 5 years? □ Yes □ No

If yes, for what condition and was the treatment effective? _____

Have you had any orthopedic problems? □ Yes □ No

If yes, please specify:_____ Are you pregnant? □ Yes □ No

Have you have a previous history of:

Past	***Present***		***Past***	***Present***	
□	□	Anemia	□	□	Kidney Disorders
□	□	Angina (Chest Pain)	□	□	Kidney Stones
□	□	Aortic Aneurysm	□	□	Prostate Problems
□	□	Arthritis	□	□	Pacemaker
□	□	Asthma	□	□	Rapid Heart Beat
□	□	Cancer	□	□	Stroke
□	□	Diabetes	□	□	Ulcer
□	□	Emphysema			
□	□	Heart Attack	Other:_____		
□	□	Hernia			
□	□	High Blood Pressure			

PATIENT INFORMATION RECORD

Type of work, examples: lifting, prolonged sitting, standing, keyboarding, etc._____

Please describe character of your current pain:

□ sharp □ stabbing □ burning □ dull □ aches □ tingling □ numbness □ soreness □ weakness □ shooting □ throbbing

How often are the complaints present?

□ Constant(76-100%) □ Frequent(51-75%) □ Occasional(26-50%) □ Intermittent(25%)

Please rate the severity of your pain: (Please circle a number below) **0** = No Pain **10**= Unbearable Pain

CURRENT: 0 1 2 3 4 5 6 7 8 9 10 **BEST:** 0 1 2 3 4 5 6 7 8 9 10 **WORSE:** 0 1 2 3 4 5 6 7 8 9 10

Since your problem started, is the pain: □ Increasing □ Decreasing □ Not Changing

Do your symptoms change throughout the day? □Yes □No

Problem began: □ Immediately after a trauma or specific incident □ Multiple incidents □ Developed over time

What aggravates your symptoms?_____

What eases your symptoms?_____

What treatment have you received for this present condition?

□ Physical Therapy □ Chiropractor □ Surgery □ Spinal Injection □ Other: _____

Have you ever had similar episodes before? □ Yes □ No

Have you, or are you currently being treated by another healthcare practitioner for this problem?

□ Yes □ No **If yes, by:** □ Chiropractor □ MD □ Other:_____

Have you had any of the following? □ X-Ray □ MRI □CT scan □ EMG □ Myelogram □ Discogram

Have you had any changes in bowel or bladder function? □ Yes □ No

Do you have fever, chills, or night sweats? □ Yes □ No

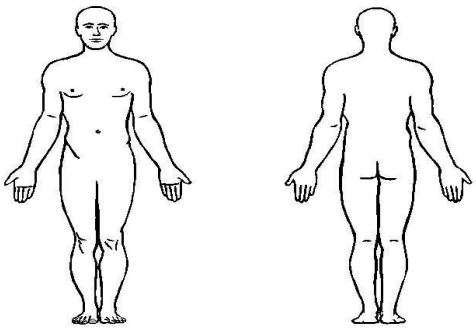
Describe daily activities:

*Present:*_____

*Desired:*_____

Please indicate location of symptoms on illustration:

Front **Back**



Name of Dr that referred you to physical therapy: _____

INSURANCE AND FINANCIAL INFORMATION

Please carefully read the following: INSURANCE IS NOT A SUBSTITUTE FOR PAYMENT: Call your insurance company if you have any questions. You are ultimately responsible for payment for any services rendered that are not paid by your insurance company.

Private Insurance: You are responsible for your deductible, and copayment, at the time of service. We will verify eligibility of benefits of your private insurance and inform you of your financial responsibility at your first visit. Once your insurance company has paid their portion, you will receive an invoice for any remaining balance. If you wish us to bill secondary insurance to you must provide us both cards at the first visit. In order to avoid delays on insurance reimbursement, please immediately inform the office staff of any change of insurance plans.

Medicare: Therapy Cap for 2018 is based on medical necessity, once patient exceeds $3,000 in YTD allowables, the patient becomes eligible for a targeted medical review, also known as an audit, determined by Medicare. Currently, Medicare covers 80% of approved charges for outpatient physical therapy services provided when your annual deductible has been met. Medicare patients who have a supplemental insurance (recognized by Medicare) must give both cards to the front office so we may bill them for the remaining 20% of Medicare approved charges. Otherwise, the patient is responsible for the 20% not covered by Medicare.

Workers Compensation: We will verify your workers' compensation claim and obtain authorization for treatment with your employer's insurance company. Only authorized visits will be scheduled. If your claim is delayed or denied, we will notify you immediately. It is important that you provide us with updated referrals to continue therapy.

Auto Claims: We require that the insured have Med-Pay available for this claim. We will verify eligibility with your auto insurance. In the event that your auto Med-Pay is exhausted, you will be financially responsible for all services rendered.

Self Pay: We do offer non-insurance/ out of pocket plans. If you wish to bill your own insurance, we require payment in full at the time of service. We will provide you with a statement of charges and a copy of the physician's referral.

Other: Broken Appointments: $50 will be charged for failing to notify us 24 hours in advance that you are unable to make your scheduled appointment.

NSF-Check Return: $25 fee will be charged if a check is returned for insufficient funds or a closed account.

Authorization to pay/ financial agreement

I hereby authorize my insurance benefits to be paid directly to Silver Creek Physical Therapy for services I receive. I expressly guarantee payment of any charges left unpaid in whole or in part or determined to be not medically necessary by the insurance Company. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I also Authorize Silver Creek Physical Therapy to release any information to process this claim and secure the payment of benefits, insurance company, attorneys, assignees and or beneficiaries. I further agree that a photocopy of this agreement shall be valid as the original.

Patient Acknowledgment: ON CLIPBOARD copy can be requested

I acknowledge that I have read a copy of the **Notice of Privacy Practices** of Silver Creek Physical Therapy. I further acknowledge that a copy of the current notice is posted in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices.

_____

Patient's /or Representative's Printed Name **Signature** **Date**

INFORMED CONSENT FOR PHYSICAL THERAPY SERVICES

Physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol.

Silver Creek Physical Therapy does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury. It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns.

It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

_____

Patient's /or Representative's Printed Name **Signature** **Date**

CONSENT FOR TREATMENT IN AN OPEN SETTING

Silver Creek Fitness and Physical Therapy, LLC in compliance with Federal HIPPA Regulations is committed to protecting our patients' health information and privacy.

The therapists and staff will make their best efforts to ensure that your protected health information is kept private at all times. Due to the industry standard of treating patients in an open setting, your treatment may be performed by your therapist in the presence of other individuals. In some instances, it is possible that other patients or staff will overhear partial information relating to your treatment, diagnosis, and insurance benefits.

By signing this Consent Form, unless you indicate in writing to the contrary, you are acknowledging the open environment and agreeing that, while not desirable, it might be possible for other patients to over hear some information regarding your treatment, and, in those unlikely circumstances, you are consenting to the disclosure of such information to any other individuals who may be present in the open therapy area.

By signing below, I acknowledge and agree to the above conditions.

_____

Patient's /or Representative's Printed Name **Signature** **Date**

INSURANCE IS NOT A SUBSTITUTE FOR PAYMENT

As a courtesy, we have contacted your insurance company to verify your benefits and we were given the following information. We have found this information **INACCURATE** at times and we highly recommend that you contact your health insurance and confirm that you are told the same information that was given to us. We are **NOT** responsible for any **INACCURATE** information given and you will be responsible for any monetary differences because of misinformation.

- ❑ **Co-payment** estimated amount of each visit: $_____
- ❑ **Deductible** estimated amount for evaluation: $_____ follow up: $_____
- ❑ **CoInsurance** _____ % estimated amount for

  evaluation: $_____ follow up: $_____

CREDIT CARD ON FILE AUTHORIZATION

Authorization
I authorize **Silver Creek Physical Therapy**, to keep my encrypted token of my credit card information on file and to directly charge my credit card account for:

- ❑ Towards charges for myself
- ❑ Towards charges for the following person:

_____ Relationship: _____
(name of patient)

- ❑ NO; I do not want my credit card save on file.

SCFPT Disclosure: PLEASE READ CAREFULLY BEFORE SIGNING

The above amount is an ESTIMATED amount.
If this does not cover your full financial liability, you will receive a bill for additional charges based on the specifics of your health coverage plan and the actual services you receive. If you have questions or want more information about your benefits, limitations, exclusions, and charges please call the telephone number on the back of your insurance card.

_____

Patient's /or Representative's Printed Name **Signature** **Date**

My benefits were explained to me by:_____

SILVER CREEK
PHYSICAL THERAPY

CANCELLATION POLICY

Patient acknowledgement is required.

There will be a $50.00 charge for cancellations not received 24 hours prior to your scheduled arrival time.

Arriving 10-15 minutes late to your appointment will also be subject to a Cancellation fee.

First Cancellation= Mulligan (do over, no fee)

Second Cancellation= $50 fee

Third Cancellation= $100 fee

All copayments, coinsurance and deductibles need to be paid on or prior to the date of service.

Your cooperation is appreciated!

_____

Patient's Printed Name **Patient's Signature** **Date**