Welcome to Todd's Body Shop Physical Therapy

Patient Name: _____ Today's Date: _____

Nickname: _____ DOB: _____ □ Male □ Female

Address: _____ City/State/Zip: _____

E-Mail Address (for appointment reminders): _____

Main Phone: _____ SSN: _____

Primary Insurance Name: _____ ID #: _____

Policy Holder: _____ DOB: _____ Relationship: _____

Secondary Insurance Name: _____ ID #: _____

Policy Holder: _____ DOB: _____ Relationship: _____

Work Comp or Motor Vehicle Accident Insurance Company Name: _____

Date of Injury: _____ Claim Number: _____

Adjuster/Case Manager: _____ Phone Number: _____

Is an attorney involved? Yes or No (circle one) Attorney/Phone Number: _____

At fault for the accident? Yes or No (circle one)

Employer Name: _____ Phone Number: _____

Employer Address: _____ City/State/Zip: _____

Referring Doctor's Name: _____

Have you completed Physical Therapy anywhere else this year? (Circle one) Yes or No

If yes, how many visits were completed? _____ Where? _____

IN CASE OF EMERGENCY CONTACT: _____

Address: _____ City/State/Zip: _____

Phone Number: _____ Relationship: _____

Missed Appointment and Cancellation Policy

Missed or late cancelled appointments will result in a $75 no-show fee that will not be waived. If you are unable to keep a scheduled appointment, please give us 24 hours advance notice.

A patient who does not show up for their appointments and has not cancelled their appointment with at least 24-hour's notice affects our other patients and the cost of care.

Thank you

Initial: _____

Todd's Body Shop Physical Therapy

Policy for Cancellations and No Shows

Required BY ALL Patients

Missed or late cancelled appointments without a 24- hour notice will result in a $75 no-show fee. This fee is separate charge that will NOT be covered by your insurance plan. You will need to pay the fee in full before you reschedule any future appointments.

This policy has been developed to assist our therapist in scheduling their patients efficiently so that each of you will be given the appropriate time when you arrive for your treatment session. We appreciate you assisting us in the matter of cancellations and no shows for our operation.

1. We require a 24-hour notice in the event of a cancellation. Missed or late cancelled appointments will result in a $75 fee that will NOT be waived.
2. Please understand that when you do not show, three people are affected:
    a) First the patient because you do not get the treatment you need as prescribed by the doctor.
    b) Second, the therapist who now has a space in their schedule, time was reserved for you personally.
    c) Third, another patient could have been scheduled for treatment if there had been proper notice.

I have read and understand that Todd's Body Shop has a $75 fee for any no-show and late cancellation. I agree to pay Todd's Body Shop no-show fees as stated above if I no-show or have not called Todd's Body Shop office at least 24 hours in advance to cancel my appointment.

Patient Signature: _____ **Date:** _____

Todd's Body Shop Physical Therapy & Rehab requires a debit/credit card or health savings account and signature on file as a method of payment. The card you provided us will be ran if there is a balance due on your account. Balance dues include no-shows, cancellations without a 24-hour notice, deductibles, co-insurance, co-pays, and charges not covered by insurance. A receipt can be sent to address upon request. I agree not to dispute the payment with my credit card company, so long as the transaction corresponds to the terms of Todd's Body Shop Physical Therapy & Rehab.

Patient Name (please print): _____

Amex/MC/Visa/Discover Card Number: _____ **Expiration Date:** _____

CCV #: _____

Signature: _____**Date:** _____

This notice/signature serves as your consent to charge the balance due on account. We do not call-in advance. Under no circumstance other than the conditions mentioned above, will Todd's Body Shop charge your credit card. In conjunction with HIPPA regulations, all credit card information will be kept confidential.

Explanation of Insurance Coverage

Most Insurance policies are cover physical therapy, but this office does not ensure yours does. Insurance policies can differ greatly in terms of coverage for physical therapy. Because of the variance of one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductible, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and we will bill your insurance company (ies) in a timely manner.

Patient Responsibility Agreement

The Physical Therapists, Physical Therapy Assistants, Techs and Staff at Todd's Body Shop Physical Therapy & Rehab appreciate the confidence you have shown in choosing us to provide you your medical needs. We are committed to providing you with the highest quality healthcare. Please read and sign this to acknowledge your understanding of your responsibility as a patient at Todd's Body Shop Physical Therapy & Rehab.

I. **Assignment of Benefits & Terms of Benefits**

Authorization of payment: I hereby assign all benefits directly to Todd's Body Shop Physical Therapy. If my insurance carrier sends me payment for services incurred in this office, I shall send or bring the full payment to your office immediately upon receipt. I understand that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment in full.

Summary of benefits is not a guarantee of payment and is subject to change. Description of benefits given to us by your insurance company is information only provided to you as a courtesy. It is the patient's responsibility to check with your insurance to verify benefits/coverage. I fully understand that any unpaid portion of services rendered is my responsibility. Quotes are an estimated calculation, according to the description of benefits given by my insurance company. I agree to the terms and conditions presented to me by Todd's Body Shop Physical Therapy & Rehab.

II. **Consent for Release of Information**

The undersigned authorizes the release of any personal health information required for treatment, payment, or health care operations. This may include physicians, case managers, and insurance carriers or third-party payers. Further, the undersigned releases of Todd's Body Shop Physical Therapy & Rehab to provide outside healthcare providers/services such information as is necessary to facilitate proper healthcare. In addition, the patient consents to the release of prior medical records from referring physicians, hospitals, case managers, or other entities, which have records necessary for proper evaluation and treatment of the patient. All other uses and disclosures will be made only with your written authorization. You have the right to revoke authorization for further uses and disclosures at any time. This release will remain I effect until terminated by me in writing: **Initial:** _____

This Information may also be released to: _____

Messages:

Please call me at my: home phone, work phone, cell phone **(circle one)**

If unable to reach me: leave a detailed message, leave a message to return your call **(circle one)**

HIPAA (Please check box and sign below)

☐ A notice of Privacy Practices has been offered to me or made available should I choose to take one.

Signature: _____ **Date:** _____

III. **Privacy Policy**

Todd's Body Shop Physical Therapy & Rehab will administer your records in a confidential manner and in compliance with the Health Insurance Portability and Accountability Act (HIPPA). A notice of Privacy practices has been offered to me or made available should I choose to take one.

IV. **Financial Contract & Agreement**

I understand that if I do not pay my account with Todd's Body Shop Physical Therapy & Rehab in full that my account may be assigned to a collection agency for collection. I understand that if my account is assigned to a collection agency that the collection agency will charge a commission or fee that may be as much as 40% of the amount, I owe to Todd's Body Shop Physical Therapy & Rehab. I agree that if my account is assigned to a collection agency that Todd's Body Shop Physical Therapy & Rehab may add the amount of the collection agency's commission or fee to the amount, I owe to Todd's Body Shop Physical Therapy & Rehab and I agree to pay the additional amount.

V. **Preparing for your Appointment**

Please plan to arrive at the requested check-in time for your appointment. New patient consultations must check-in 15 minutes prior to their appointment. This gives us ample time to get all patient information entered into your account, collect your co-pay, and have tech begin therapy as needed.

VI. **Late Arriving Patients**

The Physical Therapists/Assistant reserves the right to request that you reschedule your appointment if you arrive after your scheduled appointment time. Late arriving patients are disruptive to our practice and to other patients.

VII. **Missed Appointments**

Our policy is that you will be charged $75.00 for a missed clinic visit or not showing up for an appointment that is not cancelled within 24 hours of scheduled time. Please help us serve you better by keeping your regularly scheduled appointments or provide us the courtesy or rescheduling well in advance of the appointment. If we are unavailable to answer your call, please leave a detailed voicemail.

VIII. **Disruptive Behavior**

Todd's Body Shop Physical Therapy & Rehab has zero tolerance for patients exhibiting disruptive behavior. Todd's Body Shop Physical Therapy & Rehab will not tolerate abusive patient displays this type of behavior they will immediately be asked to leave the premises and reported to the appropriate authorities.

IX. **Payment Policy**

All co-payments, co-insurance and deductibles are expected to be paid at the time of service or prior to service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from the patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. You are responsible for services denied by your insurance as not medical necessary and or not covered. There are several patient responsibility components that may apply to an insurance payment.
Co-Payment- A set dollar amount per office visit that is the patient's responsibility
Co-Insurance- A percentage of the charge that is the patient's responsibility
Deductible- A set annual amount that the patient is responsible for paying prior to his/her insurance making a payment.

X. **Insurance Changes**

You are responsible for notifying us immediately should your insurance change. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the resulting balance.

XI. **Cash Patients**

Cash Payments are accepted at an already- discounted rate and payment is due at the time of service.

XII. **Open Balance**

A $15 administrative fee will be added to each month a statement is sent due to an open balance.

I have read and agree to the above patient responsibility agreement. We reserve the right to dismiss patients from our practice that do not adhere to these patient responsibilities. Thank you for understanding the importance of keeping appointment.

Patient Signature: _____ **Date:** _____

To our Medicare Patients Only:

We accept Medicare. We will submit your claim to Medicare, but you will be responsible for any deductibles, co-insurance or ANY charges NOT covered by Medicare and/or your secondary insurance should you have one.

Secondary Insurance: this office will NOT file your secondary insurance claims. If your secondary insurance has NOT paid within **90 days** of the date of service, payment for services becomes the patient's responsibility.

Possible Required Deductible:

Medicare typically has an annual deductible. Some secondary insurances may cover this deductible, others will not. We will try and assist you in identifying your financial responsibility and will collect this amount if required.

We will be closely monitoring our service so we can provide you with the highest quality care available.

Should you have any questions regarding any of this information, please do not hesitate to ask.

1. In **this** calendar year, have you received any of the following:

	Circle one	If yes, where & # of times?
Physical therapy?	yes/no	
Occupational therapy?	yes/no	
Speech therapy?	yes/no	
Home health services?	yes/no	
Treatment at an outpatient facility?	yes/no	
Seen at a doctor's office?	yes/no	

Patient Signature: _____ **Date:** _____

Depression Scale

Required by the Insurance: Please fill out if you are over the age of 12

Instructions: Circle the best answer for how you have felt over the past week

1.	Are you basically satisfied with your life?	Yes or No
2.	Have you dropped many of your activities and interests?	Yes or No
3.	Do you feel that your life is empty?	Yes or No
4.	Do you often get bored?	Yes or No
5.	Are you in good spirits most of the time?	Yes or No
6.	Are you afraid that something bad is going to happen to you?	Yes or No
7.	Do you feel happy most of the time?	Yes or No
8.	Do you often feel helpless?	Yes or No
9.	Do you prefer to stay home, rather than going out and doing new things?	Yes or No
10.	Do you feel you have more problems with memory than most?	Yes or No
11.	Do you think it is wonderful to be alive now?	Yes or No
12.	Do you feel worthless the way you are now?	Yes or No
13.	Do you have energy?	Yes or No
14.	Do you feel that your situation is hopeless?	Yes or No
15.	Do you think that most people are better off than you are?	Yes or No

Medical History: **Please circle all that apply**

Angina/Chest Pain	Diabetes	High Blood Pressure	Seizures
Asthma	Diverticulitis	High Cholesterol	Stroke
Arthritis	Ear Infections	Hypoglycemia	TB
Blackouts	Endometriosis	Menopause	Other _____
Blindness	Fibroids	Migraine Headaches	
Blood Clots	Fibromyalgia	Major Spinal Injury	
Bowel/Bladder Problems	Fractures	MRSA	
Chest/Abdominal Pain	Frequent Falls	Osteoporosis	
Coronary Artery Disease	Hearing Problems	Pacemaker	
Cancer	Heart Disease	Poor Circulation/Raynaud's	
Depression	Hepatitis	Polio	

Medical Questionnaire **(please complete entire form)**

Name: _____ Date: _____

Age: _____ Height: _____ Weight:_____

Employer/Occupation: _____ Currently Working: Yes or No

Who referred you to physical therapy? _____

Prior treatment: _____

Do you have a pacemaker? Yes or No Are you pregnant: Yes or No

Are you using tobacco products? Yes or No

Chief Complaint: _____ Side of Injury? Right or Left

When did your symptoms begin: _____

My symptoms are made better by: _____

My symptoms are made worse by: _____

Does your pain wake you up at night? Yes or No If yes, how often? _____

My symptoms are (circle one): CONSTANT INTERMITTENT CHRONIC NEW

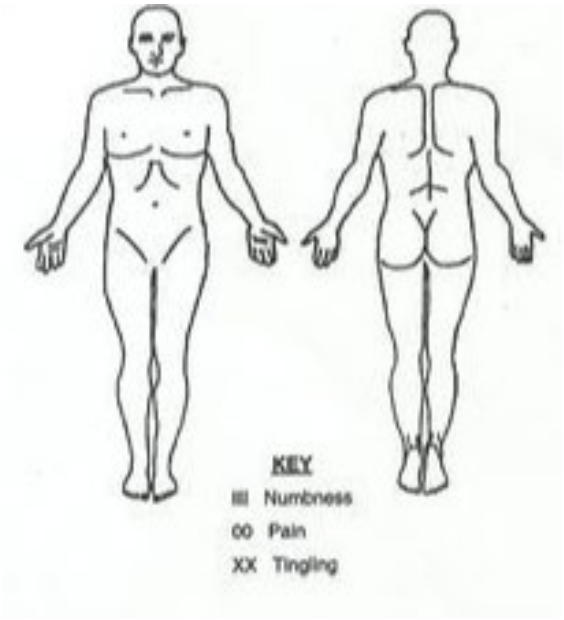
Are your work activities or daily living limited? (Circle one) YES PARTIALLY NO

Please list all allergies: _____

Please list all surgeries: _____

What medications, if any, are you using? _____

Please mark where your chief complaint is



Please circle your current level of pain