Comprehensive Orthopedic Rehabilitation of Edmond

CORE Physical Therapy

FINANCIAL AGREEMENT

I understand and agree that I am totally responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I understand that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am primarily responsible for all charges regardless of my existing medical coverage. In the event that my insurance company forwards payment directly to me, instead of Core Physical Therapy, I will immediately deliver such payment directly to Core Physical Therapy. I understand and agree that if it becomes necessary to commence legal action for the collection of any outstanding charges on my account, I will be responsible for any costs and or court fees, in addition to the outstanding balance. There will be a 1.5% late charge of any balance 90 days or over; once the insurance company pays. *Please initial* _____.

I hereby give authorization for payment of insurance benefits to be made directly to Core Physical Therapy for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of the agreement is as valid as the original.

_____ Date _____/_____/_____

Signature *(Parent or guardian signature if patient is a minor)*

APPOINTMENT POLICY

I understand that my doctor has prescribed therapy for me and that physical therapy is an ongoing process which requires regular attendance to be optimally effective.

APPOINTMENTS

Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival of greater time than 15 minutes may result in a shortened treatment or cancellation. We require advance notice of 24 hours of cancellation. Failure to show for an appointment or cancellation without sufficient notice may be subject to a $25.00 charge.

CO-PAYMENT POLICY

Patients that carry health care insurance should remember that some policies require a copayment for each visit. Consequently it is your responsibility as defined by your policy to make these copayments. Also important is that you are responsible for any and all supplies, such as braces and exercise equipment, which are provided to you and are not covered by your particular plan. I understand and agree that I am solely responsible for all copayments and charges incurred which are not covered under my health care plan. I also authorize the release of any medical information necessary to process this claim.

AUTHORIZATION FOR TREATMENT

I hereby consent to and authorize all therapy treatments, which in conjunction with the judgments of the attending physician may be considered necessary or advisable for the diagnosis or treatment of the above named patient at Core Physical Therapy. I realize that I am a integral part of the rehabilitation process and will be sufficiently educated about treatment and alternatives before they are performed. *Please initial* _____.

_____ Date _____/_____/_____

Signature *(Parent or guardian signature if patient is a minor)*

Patient Name _____

Comprehensive Orthopedic Rehabilitation of Edmond

CORE

Physical Therapy

ASSIGNMENT/AGREEMENT FOR PAYMENT

1. Patient requires physical therapy treatment that **CORE Physical Therapy** will provide.

2. Patient does not wish to pay cash for the physical therapy treatment services at the time they are rendered; instead, the patient wants this Physical Therapist to act in the patient's behalf by collecting sums owed to **CORE Physical Therapy** from any person, third party payor, attorney, personal auto insurance carrier, or Insurance Company which has an obligation to pay or reimburse patient for his/her medical expense for physical therapy treatment.

3. This physical therapist agrees to treat the patient on this basis only if patient permits this physical therapist to act exclusively on behalf of the patient in collecting medical expenses as described in the paragraph above. This agreement shall be irrevocable by the patient until **CORE Physical Therapy** has been fully paid for all charges in connection with the physical therapy services provided by **CORE Physical Therapy** to this patient. Any attempt by the patient to revoke this agreement shall be null and void and of no effect prior to the payment-in-full of this physical therapist's charges.

4. Patient agrees to allow payment to be made directly to **CORE Physical Therapy** for services rendered, and has read and understands this agreement prior to the signing of this agreement.

   Patient acknowledges personal responsibility for the physical therapy charges and Understands that this agreement is only an inducement for **CORE Physical Therapy** to extend credit to the patient.

Witness: _____ Physical Therapist: _____

Witness: _____ Patient: _____

Date: _____ Date: _____

Patient Information

Date:_____

First Name: _____ **Middle**: _____**Last**: _____ ☐**Male** ☐ **Female**

Address:_____**City**:_____ **State**: _____**Zip**: _____**Marital Status**:_____

Home Phone: (____)_____ **Cell Phone**: (___)_____

Date of Birth: _____ **Age**:_____ **SSN**: _____ **Email** _____

Employer: _____**Work Phone**: _____

Address: _____ **City**:_____ **State**: OK **Zip**: _____

Emergency Contact: _____**Relationship to Patient**: _____ **Phone**:(____)_____

PCP/Referring Physician: _____ **Phone**: (____) _____

Date last seen by attending/referring physician_____/_____/_____ ***UPIN #:****(office use)* _____

How did you hear about us? _____

INSURANCE INFORMATION

Name of Policy Holder: _____Date of Birth: ____/_____/_____SSN: _____

Relationship to Patient: _____ Employer Name: _____ Work Phone: (____)_____

Insurance Company Name: _____Phone: (____) _____

Claims Address: _____City: _____State: _____ Zip: _____

Policy Number: _____Group Number: _____

Is Pre-authorization or referral required by your PCP? ☐Yes ☐No Auth #: _____ # of Visits: _____

Does the patient have additional Insurance Coverage? ☐Yes ☐No

Secondary Policy Holder Name: _____Date of Birth: ____/____/_____ SSN: _____

Secondary Insurance Company Name: _____Phone: (____) _____

Claims Address: _____City: _____State: _____ Zip: _____

Secondary Policy Number: _____ Group Number: _____

Have you ever had Physical Therapy for this injury? ☐Yes ☐No If yes, where: _____

Is this case currently involved in litigation? ☐Yes ☐No

Is there an Attorney involved? ☐Yes ☐No If yes, Attorney Name: _____ Phone: _____

Patient's Authorization to Disclose Medical Records

I, _____, authorize **Core Physical Therapy, Inc.** to release medical information to be used on my behalf to the following**:**.

Referring Physician's Name: _____

Your Insurance Company _____

Other Physician/Other Insurance: _____

Please ***initial*** the following to authorize:

_____ I consent to treatment by a physical therapist.

_____ I specifically authorize the release of physical therapy records and any physician's orders for therapy, to the parties mentioned above.

_____ I authorize Core Physical Therapy, Inc. to bill my insurance company and furnish information to them concerning my treatments.

_____ I assign to Core Physical Therapy all payments for services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

_____ I understand that I will be billed for any appointments canceled with less than 24 hours notice.

_____ I have been informed that this office's ***Notice of Privacy Practices (HIPPA)*** is available upon request and is on display to review on anytime. I can obtain a copy by request.

May we leave the following information on your answering machine at home or work? **(*Please Initial*)**
Appointment/Schedule confirmations with date and time? Yes_____ No_____
Financial Information? Yes_____ No_____

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire one year from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Signature of Patient _____

Date _____

(Parent or Guardian if applicable) _____

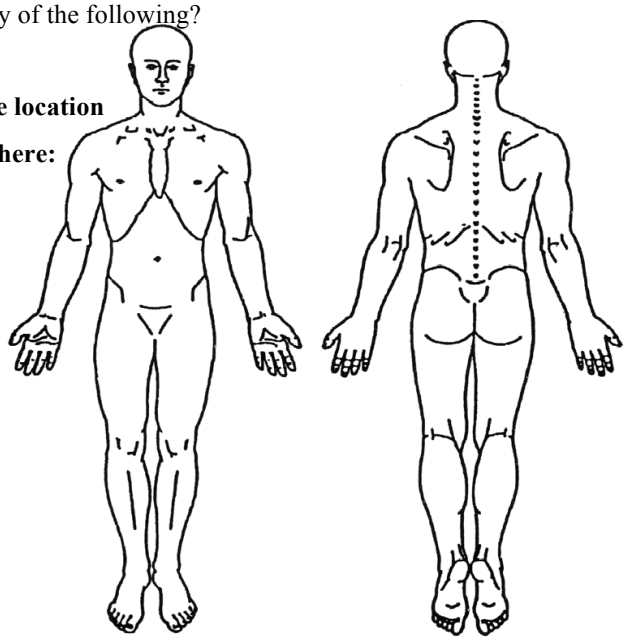
Date _____

For Office Use
We attempted to obtain a written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:
____Individual refused to sign
____Communication barriers prohibited obtaining the acknowledgment
____An emergency situation prevented us from obtaining acknowledgment
____Other (Please Specify) _____

Have you ever had any of the following?

	Yes	No
High Blood Pressure	☐	☐
Cardiac Conditions	☐	☐
Metal Implants	☐	☐
Nervous Disorders	☐	☐
Pacemaker	☐	☐
Seizures	☐	☐
Dizzy Spells	☐	☐
Diabetes	☐	☐
Allergies	☐	☐
Fractures	☐	☐
Stroke	☐	☐
Arthritis	☐	☐
Vision Problems	☐	☐
Are you pregnant?	☐	☐
Cancer	☐	☐
Circulation Problems	☐	☐

Please indicate location of symptoms, here:



XXX	Sharp localized pain
////	burning
OOO	Numbness and tingling
→	Shooting pain

Any other illnesses or diagnoses? ☐ Yes ☐ No Please explain: _____

_____

Have you ever had surgery? If so, please describe: _____

_____

List any medications you are currently taking or attach list: _____

_____

Have you had physical therapy this calendar year? _____

Date of injury/onset of current symptoms: _____

What happened? _____

_____

Patient Name_____Date_____

Please note that CORE hates paperwork. This information is used to show a medical necessity for your current health insurance plan so your insurance provider will cover cost as quoted to both parties associated with your treatment. We apologize that Uncle Sam has gotten so involved with making all parties involved do more paperwork. Please be as inclusive as possible to show a need for skilled treatment.

Current Pain: walking in the door today? 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10

Most pain in past 24 hours? Pain: 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10

Pain medication in past 24 hours No or Yes, if yes-what/when_____

Age:_____	Profession:_____
Duration of symptoms:_____	Highest Level of Education Attained:_____
Past PT experience: Positive or Negative	Dependable Family Support: Yes or No
High Stress Level: Yes or No	Hectic Work Schedule: Yes or No

Please Circle any/all items that are currently challenging:

Stairs	Recreational Activities	Shopping
Household chores	Dressing	Attending Public Events
Yard Work	Self Care	Rising from low surface
Prolonged Walking	Prolonged Standing	Playing with grandkids

Please Circle any/all items that you or someone close to you currently experiences:

Obesity	Cardiovascular Disease	Cancer
Tobacco use	Cardiopulmonary Disease	Hearing loss
Diabetes	Autoimmune Disorders	Visual Deficits
Physically inactive	Psychological Disorders	COPD
Asthma	Congestive Heart Failure	Depression

Feel free to elaborate below on any items circled above:

PERSONAL INJURY FORM

Patient Name:_____

Date of Accident/Injury: _____Time:_____am/pm (please circle one)

Cause: _____

Place (be specific): _____

Injury to (such as back, knee, neck):_____

I was: ☐ Driving my car ☐ Passenger in my car ☐ Pedestrian
☐ Driving another's car ☐ Passenger in another's car ☐ Other_____

Please list information regarding your automobile insurance company (or the insurance company of the owner of the vehicle in which you were a passenger or driver) **and** the insurance company of the third party (other vehicle involved, if any). If this injury is related to other than an automobile accident, please list the insurance company of the other party involved in this injury.

Patient's Auto (PIP) Insurance Company: _____

Mailing Address: _____

_____

Insured's Name: _____Claim Number: _____

Insurance Claims Adjuster: _____Telephone #:_____

I do not wish insurance billing or medical records to be issued to this party._____

Reason: _____

Third Party Insurance Company: _____

Mailing Address: _____

_____

Insured's Name: _____Claim Number: _____

Insurance Claims Adjuster: _____Telephone #:_____

I do not wish insurance billing or medical records to be issued to this party._____

Reason: _____

Please check the appropriate boxes below:

I have automobile insurance PIP (medical) coverage: ☐ Yes ☐ No
My automobile insurance PIP is exhausted: ☐ Yes ☐ No
I have personal Medical Insurance: ☐ Yes ☐ No
I have retained an attorney: ☐ Yes ☐ No
If yes: Attorneys' Name: _____ Telephone #:_____
Mailing Address: _____
I do not wish insurance billing or medical records to be issued to this party._____

Reason:_____

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