Dutch Physical Therapy New Patient Information | 2017

First Name: _____ **Middle Initial**: _____ **Last Name**: _____

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

What is the best number to reach you at to confirm appointments? Home | Cell | Work

Birth Date: _____ /_____ / _____ **Sex**: M / F **Social Security No**.: _____ -_____ - _____

Street Address: _____**City**: _____**State**: _____ **Zip**: _____

Email address: _____ (would you like to be added to our email list? Yes / No)

Marital Status: single married divorced widowed other **Employment status**: full time part time student retired other

Employer: _____ **Employer Phone**: _____

If Married, Spouse's Name, Employer & Phone Number_____

Responsible Party Information: Patient's Relationship to responsible Party: Self | Spouse | Child | Other

Name: First_____MI_____Last_____ Home Phone No.: _____

Address: _____ City, State, Zip Code:_____

Employer: _____ Employer Phone: _____

Person/Relative Not Living With You: _____ Phone No.: _____

How did you hear about us? Check all that apply:

Doctor | Friend/Family | Billboard | Postcard | Newsletter | Email | Seminar | Website | Ins Network | Other: _____

Whom may we thank for referring you?_____

Referring Physician: _____ Primary Physician: _____

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Injury/Accident Related? Yes / No Date of Accident: _____ Do you have an Attorney? Yes / No

If Yes, Please give Attorney Name and Phone No.: _____

If an accident, is this a Work related injury or Motor Vehicle Accident? (Yes or No) If yes, what is your claim no.?_____

Please give the name of the at fault parties Insurance Carrier/Workers Comp. Payer: _____

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Has the patient received any type of physical/occupational therapy and/or home health services within the current calendar year? (For this injury or any other injury) YES / NO

If yes, explain:_____

Have you been discharged or are you currently treating? _____

If yes, Please give name and phone no. of the Home Health Agency: _____

If yes, Please give the name of the clinic or facility: _____ How many visits were received? _____

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Authorization and Assignment

I authorize Dutch Physical Therapy, Inc. to release medical information that may be necessary to request claim reimbursement from insurance companies or other payors to whom claims may be submitted. I also assign claim payments including major medical benefits to be made payable to Dutch Physical Therapy, Inc. I understand that Dutch Physical Therapy, Inc. will refund to me any overpayment upon request, regardless of insurance. This authorization and assignment may be revoked by me at any time by a written notice.

I ACKNOWLEDGE THAT I HAVE RECEIVED A NOTICE OF PRIVACY PRACTICES (available upon request)

Patient Name (Print): _____ **Date:** _____

Patient or Legal Guardian Signature: _____ **Date:** _____

Dutch Physical Therapy- Cancellation Policy | 2017

To Our Patients Regarding
CANCELLATION AND NO SHOWS

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic, because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist has prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your goals in treatment.

- **WE REQUIRE 24 HOURS NOTICE IN THE EVENT OF A CANCELLATION**. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible. (In some cases, this may not work since some forms of treatment do not work well if given two sequential days.)

- You may need to see a therapist other than the one who normally treats you if you do re-arrange your appointment. All of our therapists are experienced professionals, and they will study your patient chart, so you will be in good hands. You will return to your original therapist on the next regularly scheduled visit.

- **THERE IS A $25.00 CHARGE FOR A CANCELLATION WITHOUT PROPER NOTICE. THIS CHARGE WILL NOT BE COVERED BY INSURANCE, BUT WILL HAVE TO BE PAID BY YOU PERSONALLY.**

- For Worker's Compensation and Personal Injury patient's documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.

- Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. Either condition can seem to be a reason not to come in: A) YOU ARE FEELING WORSE AND THINK THE TREATMENT IS NOT WORKING, or B) YOU ARE FEELING BETTER AND IT IS A GREAT DAY FOR WINDSURFING. Neither of these conditions legitimate as a reason not to come: A) IF YOU ARE IN PAIN, COME IN AND GET FIXED, B) IF YOU ARE OUT OF PAIN, NOW IS THE TIME THAT WE CAN BEGIN DOING SOME REAL CORRECTION OF THE UNDERLYING CAUSES OF YOUR PROBLEM AND EDUCATE YOU SO YOU WILL NOT RE-INJURE YOURSELF, ETC.

- When you do not show as scheduled, three people are hurt: 1) YOU BECAUSE YOU DO NOT GET THE TREATMENT YOU NEED AS PRESCRIBED BY THE DOCTOR AND/OR PT, 2) THE THERAPIST WHO NOW HAS A SPACE IN THEIR SCHEDULE SINCE THE TIME WAS RESERVED FOR YOU PERSONALLY, AND 3) and ANOTHER PATIENT COULD HAVE BEEN SCEDULED FOR TREATMENT IF YOU HAD GIVEN PROPER NOTICE.

Please cooperate with us in this regard. We are looking forward to working with you.

_____ _____

PATIENT'S SIGNATURE DATE

_____ _____

INTERVIEWER SIGNATURE DATE

FINANCIAL RESPONSIBILITY – CANCELLATIONS – CONSENT FOR TREATMENT
MEDICAL RELEASE AND ASSIGNMENT OF INSURANCE BENEFITS

PATIENT NAME: _____**DATE:** _____

FINANCIAL RESPONSIBILITY

I/We certify that the information provided to Dutch Physical Therapy is true and correct to the best of my knowledge and belief. In consideration of the physical therapy services and/or treatments rendered to the above named patient, I/We assume responsibility for and guarantee the payment of all service and/or treatment charges in accordance with the practice's then current rates. The patient portion of all charges is due and owing at the time services and/or treatments are rendered. The legal judicial interest rate will be added to all unpaid balances which are more than thirty (30) days delinquent. I/We also agree that, except as provided by law, I/We shall be responsible for the payment of any service and/or treatment charges which for any reason are not paid by any payor or insurance company. I also authorize Dutch Physical Therapy to initiate a complaint to the Insurance Commissioner in my name and to deposit checks made in my name. In the event this account is rendered delinquent and is placed in the hands of an attorney for collection and/or resolution of account disputes, regardless whether formal legal action is instituted, I/We agree to pay, in addition to the principal amount due and owing, a fee of fifty (50%) percent of the principal amount as well as all costs incurred in connection with said collection. I/We acknowledge that in addition to the face amount of the check, additional fines, fees and penalties will apply to all NSF and/or stop-payment checks as provided by law, including but not limited to a **twenty-five ($25.00) dollars NSF service charge** and/or fifteen ($15.00) dollars stop-payment service charge, and agree to pay such prior to the rendering of further physical therapy services and/or treatments. **NOTICE TO PATIENTS PAYING BY CREDIT CARD - I/We authorize Dutch Physical Therapy to charge against said credit card all unpaid balances which are more than ninety (90) days delinquent, which pre-authorization will remain in effect until I/We deliver to Dutch Physical Therapy written notification of revocation in such time and manner as to afford Dutch Physical Therapy the reasonable opportunity to act upon said revocation.**

CONSENT FOR TREATMENT

I/We acknowledge that physical therapy services and/or treatments, to a greater or lesser degree, may result in weakness, paralysis, pain, numbness and/or limitation of movement and being mindful of such risks agree and consent to all procedures and medical services and/or treatments deemed necessary by Dutch Physical Therapy and/or the patient's physical/occupational therapist. I/We acknowledge that all information provided is made in the best professional judgment of Dutch Physical Therapy and being mindful of the uncertain nature of complications that there is no guarantee, expressed or implied, as to the success or other results of the physical therapy services and/or treatments rendered.

MEDICAL RELEASE AND ASSIGMENT OF INSURANCE BENEFITS

I/We authorize Dutch Physical Therapy to release all medical records, billing information and/or other protected health information, which may be of a sensitive nature to the Social Security Administration, health maintenance organizations, worker's compensation carriers, employers, or persons acting on behalf of a preferred provider arrangement (or any of their agents or representatives), when such information is requested for payment, utilization review or coverage determination purposes. I/We understand that this authorization is strictly voluntary, that I/We may refuse to consent to such and may revoke such consent at any time, except in instances where a particular action depends upon the consent remaining in effect, including but not limited to securing full payment of the account(s). This authorization shall remain in effect for the greater of a period of not more than two (2) years from the above indicated date or until payment of this account is rendered in full. The authorization to release medical information herein contained shall also apply to all physical/occupational therapists employed by and/or contracted through Dutch Physical Therapy. I/We further authorize any such payor or insurance company to pay directly to Dutch Physical Therapy all benefits due and payable as a result of physical therapy services and/or treatments rendered by Dutch Physical Therapy. I/We hereby assign to any physical/occupational therapist providing manual and physical therapy or other services rendered in connection with this treatment, all benefits due me for such services and/or treatments under any applicable policy of insurance. I/We accept the financial responsibility to Dutch Physical Therapy and/or said physical/occupational therapist for all charges for services and/or treatments not paid by any payor or insurance company and hereby promise to pay within thirty (30) days of the date of service and/or treatment any remaining balance.

_____ _____
SIGNATURE OF PATIENT OR PATIENT'S LEGAL GUARDIAN **DATE**

_____ _____
RELATIONSHIP TO PATIENT **SIGNATURE OF WITNESS**

SUPPLIES WAIVER

Patient Name: _____

Account # _____

Date of Purchase: _____

Supplies Purchase: _____

_____

_____

This is an advanced notice that Dutch Physical Therapy is not a DME supplier for your insurance. Therefore, a claim for the above listed supplies will not be billable to your insurance and you (the patient) are responsible at 100%. By signing below you (the patient) agree to make payment to Dutch Physical Therapy **if you purchase supplies**.

_____ _____

Patient Print Name Date

_____

Patient Signature

_____ _____

Witness Date

Dutch Physical Therapy Medicare Requirements | 2017

Due to recent changes in Medicare policies we are required to collect the following information in addition to completing a functional index survey every 10th visit.

First Name: _____ **Middle Initial**: _____ **Last Name**:

_____

Date: _____ /_____ / _____

Height: _____**Weight:** _____

Pain Level: (Circle one) ☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

List Medications Currently Taking:

Prescription or OTC Drug	Frequency Taken	Dosage
Ex: Celebrex	**twice daily**	**10mg**

Authorization and Assignment

I authorize Dutch Physical Therapy, Inc. to release medical information that may be necessary to request claim reimbursement from insurance companies or other payors to whom claims may be submitted. I acknowledge that this information is true and correct to the best of my knowledge.

Patient Name (Print): _____ **Date:** _____

Patient or Legal Guardian Signature: _____ **Date:** _____

DUTCH PT Physical Therapy

Name: _____

Pain Levels:

Current: _____ Best: _____ Worst: _____

No Pain **Moderate Pain** **Unbearable**

☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

Indicate the Location of your pain:

Key:

0000	**Pins and Needles**
XXXX	**Burning**
|||||	**Stabbing**
+++++	**Aching**
____	**Other**