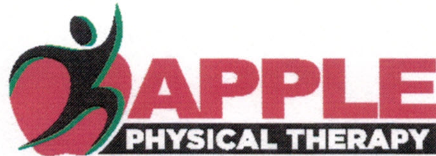


ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the Notice of Privacy Practices for FACILTY. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to FACILTY to release any of my protected healthcare information.

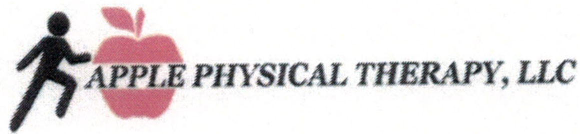
____

Patient's or Authorized Representative's Printed Name & Date

____

Patient's or Authorized Representative's Signature

Copyrights Protected By BCMS, Inc.
Written Authorization For Use Required

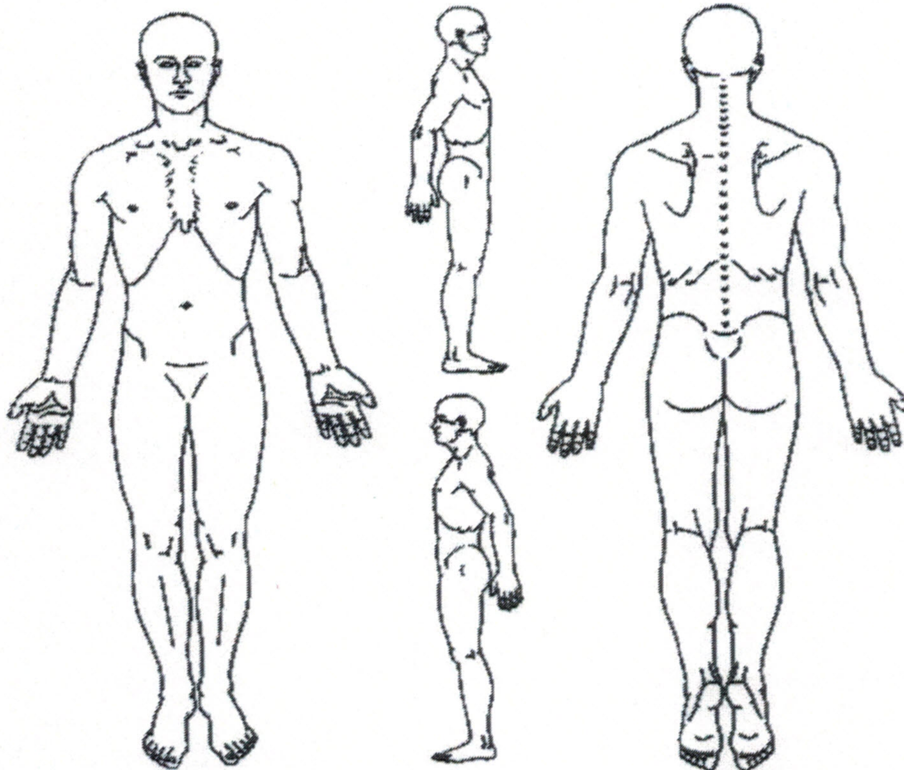


SYMPTOM DIAGRAM

Patient's Name________________________________ Date__________________

Use the following drawing to indicate the location of your symptoms at the present time.
Use the various symbols to describe the symptoms.

SHARP PAIN	ACHINESS	BURNING	PINS AND NEEDLES	NUMBNESS
////	XXX	!!!!	0000	++++



Instructions: Rate your major area of pain on the 0-10 Pain Rating Scale below:

0	1	2	3	4	5	6	7	8	9	10
No pain		Weak	Moderate		Strong		Very Strong		Maximal Pain	

Please rate your pain (0-10) at rest and with activity in the spaces provided:

With Activity____________________________ At Rest______________________

Background Information & Medical History Form

To ensure you receive a complete and thorough evaluation, please provide us with information regarding your health status found on this form. If you do not understand a question, leave the area blank and your therapist will assist you. Thank you!

Name: ______________________________ Date: ______________

Are you currently: (check one)
- ☐ Working at your usual job with no restrictions.
- ☐ Working at your usual job with restrictions.
- ☐ Unable to work because of your condition since: ________
- ☐ Unable to work due to other medical reasons.
- ☐ Retired / Unemployed / Homemaker

Have you ever had physical therapy for this condition?

Circle: YES NO

Are you seeing:
- ☐ Medical Doctor
- ☐ Osteopath
- ☐ Dentist
- ☐ Physical therapist
- ☐ Psychiatrist/Psychologist
- ☐ Chiropractor

If you have seen any of the above during the last three months, please describe the reason (illness, medical conditions, injury, routine physical, etc.).

____

____

____

Have you EVER been diagnosed as having any of the following conditions:

Yes No Heart Problems
Yes No High blood pressure
Yes No Stroke
Yes No Rheumatoid Arthritis
Yes No Other Arthritic Problems
Yes No Epilepsy
Yes No Lung Disease
Yes No Emphysema/Bronchitis
Yes No Asthma
Yes No Chemical Dependency
Yes No Hearing loss/disorder
Yes No Eye Disease
Yes No Muscle disease/disorder
Yes No Multiple Sclerosis
Yes No Diabetes
Yes No Tuberculosis
Yes No Hepatitis
Yes No Kidney Disease
Yes No Thyroid Problems
Yes No Depression
Yes No Circulation Problems
Yes No Osteoporosis
Yes No Cancer:
If yes, what kind: ____________
Yes No Past Pregnancy:
Delivery (please circle): vaginal cesarean
Yes No Currently Pregnant? ______ months
Yes No Other: ______________________

Please list any surgeries or other conditions for which you have been hospitalized, including dates and reasons.

Date	SURGERY	REASON:

Please describe any injuries for which you have been treated (fractures, dislocations, sprains/strains).

Date	INJURY	Date	INJURY

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for the following?

Yes No Diabetes
Yes No Heart disease
Yes No Arthritis
Yes No High blood pressure
Yes No Epilepsy
Yes No Chemical dependency
Yes No Tuberculosis
Yes No Cancer
Yes No Headaches
Yes No Mental Illness

Which of the following OVER-THE-COUNTER medications have you taken in the past week?

Yes No Aspirin
Yes No Advil/Motrin/Ibuprofen
Yes No Tylenol
Yes No Decongestants
Yes No Antacids
Yes No Laxatives
Yes No Antihistamines
Yes No Vitamins/Mineral Supplements
Yes No Other: ______________________

List all PRESCRIPTION medicines you are currently taking (pills, injections, and skin patches):

____

____

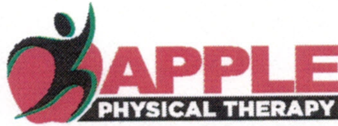
Medicine Allergies: ______________________________

How much caffeine per day? ________ Cigarettes smoked per day? ________ Days a week you drink alcohol? ________

Have you recently noted:

Yes No Weight loss/gain
Yes No Nausea/Vomiting
Yes No Fatigue
Yes No Weakness
Yes No Fever/Chills/Sweats
Yes No Numbness or tingling
Yes No Menstrual Irregularities
Yes No Bladder Irregularities
Yes No Rectal Bleeding

Form reviewed with patient: YES NO Therapist signature: ______________________________



PATIENT AUTHORIZATION AND GUARANTEE

****IMPORTANT: PLEASE READ THIS CAREFULLY*****

RELEASE OF INFORMATION

I hereby authorize the release of any information by telephone or in writing, including reports of diagnosis, treatment, prognosis, recommendation, benefits payable, as well as any other data pertinent to my treatment by Apple Physical Therapy to my physician(s), as well as any organization responsible for payment of my account, and any legal representative involved in my litigation. I also authorize the release of any information by telephone or in writing for utilization and quality review purposes.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize that the payment of authorized benefits be made directly to APT for any services that are reimbursable by Medicare, Medicaid, or any third party sources.

VALUABLES

I hereby understand that APT is not responsible for valuables and personal property brought to the facility.

CONSENT OF TREATMENT

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while I am a patient of APT.

GUARANTEE OF ACCOUNT

In consideration of services rendered to me by APT, I hereby guarantee payment for any and all services rendered to me in which are not covered or allowable by insurance, together ,with collection costs, including reasonable attorney fees. I understand that there may be a charge for supplies that are needed during my course of treatment that will not be covered by my insurance and for which I am financially responsible. I also understand that I may have a copayment, co-insurance and/or deductible for which I am fully responsible for paying. Although APT will inform me of my insurance coverage for physical therapy, it is ultimately my responsibility to understand my insurance benefit limitations and payments. I will immediately notify APT of any changes in my insurance coverage while receiving physical therapy.

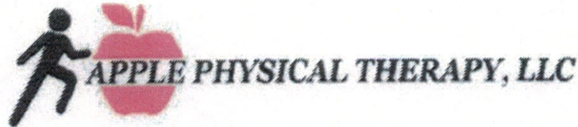
MEDICARE

I hereby certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any such information needed for this or a related Medicare Claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and co-insurance.

I, ______________________________, by signing this document, acknowledge my consent to the above:

(Print Name)

Signature_________________________________ Date:____________________________



APPLE PHYSICAL THERAPY CANCELLATION/NO SHOW POLICY

Apple Physical Therapy takes the subject of canceling your appointment very seriously, as it can make the difference as to whether you recover from your injury or condition. Showing up as scheduled is one of your most important responsibilities.

Apple Physical Therapy requires 24 hours notice for the cancellation of a scheduled appointment. Please have an alternative appointment time in mind for that week when you call to cancel. It is important that you receive your full amount of prescribed treatment since many insurance companies restrict physical therapy benefits. Your prescribed number of visits is determined by your physical therapist after your initial evaluation.

There is a $20 charge for a no-show or cancellation WITHOUT proper notice. This charge will NOT be covered by your insurance, but will have to be paid by you personally.

We take this policy seriously because when a patient misses an appointment, three people are adversely affected:

1.) You, the patient --for not receiving the treatment you need.
2.) Your therapist – as now he or she has an empty space in the schedule, since the time was reserved for you personally.
3.) Another patient – who could have had your appointment time to receive treatment.

Sometimes, you may feel you should not attend physical therapy for the following reasons

1.) You may continue to have pain or feel your pain is worsened. Please understand your pain may fluctuate as your course of treatment progresses and before you complete therapy. It is important to come in if you are in pain because there are treatments available that can lessen those symptoms.

2.) You are experiencing less pain. This is also not a reason to cancel or fail to show for your scheduled treatment. That is the point in your treatment progression to begin correction of the underlying causes of your problem and educate you as to how to avoid re-injury in the future.

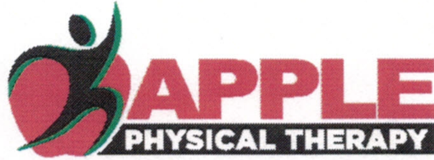
As you can see, neither of these reasons are legitimate reasons to not keep your scheduled appointment.

Please cooperate with us in this regard, and we will have you out of pain and feeling better soon. We are looking forward to working with you.

I consent to the above, as indicated by my signature below:

(print name)________________________________

(signature)________________________________ (Date)____________________



PATIENT RESPONSIBILITY OF PAYMENT

Date:______________________

Dear:______________________

______We verified your coverage for outpatient physical therapy benefits with your health insurance provider. Under your coverage, you are responsible for a $_______________ co-pay amount due to Apple Physical Therapy at the time of each visit. This co-pay can be paid using cash, credit card or check. You can pay either at the time of each visit, or one time weekly, as long as it is within the week in which you receive your physical therapy treatments.

______ We verified your coverage for outpatient physical therapy benefits with your health insurance provider. Under your coverage, you are responsible for a co-insurance amount of _______% with a deductible of $_________ which is due after we bill your health insurance. You will receive this bill from Apple Physical Therapy after we receive the amount due by your health Insurance provider.

______ We verified your coverage and your Workman's Comp or Motor Vehicle coverage has verified that your claim is opened and you can be seen. We do not however, accept your health care insurance and if Workman's Comp or Motor Vehicle does not cover any of your treatment, you will be responsible for any uncovered expenses.

______ We verified your coverage, and your Workman's Comp or Motor Vehicle coverage has verified that you can be seen. If Workman's Comp or Motor Vehicle does not cover any of your treatment, you must obtain a referral from your health insurance coverage as a back-up to cover any uncovered expenses. Your health insurance will NOT be billed, unless Workman's Comp or Motor Vehicle does not cover. If you do not provide this referral, you will be responsible for any uncovered expenses.

Other:____

____

The information we receive from your insurance company may not be accurate. Therefore, the information provided above is not a guarantee but rather an estimate and is subject to change. We may not know the exact coverage until we receive correspondence after claims are submitted to your insurance company. Additionally, there may be some services that are not covered by your insurance provider. If your insurance provider does not cover a service you receive, you are responsible to pay for uncovered services.

We encourage you to call our billing office with any questions or concerns you may have at (800) 438-1487. Our commitment is to provide you with the best service that we can.

We strongly recommend that you personally verify your coverage and financial responsibility for outpatient physical therapy directly with your insurance company. Please notify us immediately of any discrepancies you identify. To verify your coverage, refer to the back of your insurance card and call the Patient Service number provided.

Thank you,
Apple Physical Therapy, LLC

I understand and will abide by the above policy.

Patient Name (Print)____ Date:_____________________________

Patient signature____