PREMIER
PHYSICAL THERAPY

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give consent for Premier Physical Therapy to furnish medical care and treatment to (patient's name) _____
considered necessary and proper in diagnosing or treating his/her physical and mental condition.
Patient/Guardian _____ Date _____

FINANCIAL POLICY STATEMENT

We bill your insurance carrier as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal ***usual and customary fee schedule***, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed by us, you recognize your obligation to promptly remit the same to Premier Physical Therapy.

I understand and agree that if I fail to make all of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees

Note: Estimated coverage information is provided as a courtesy to our patients, but is not intended to release them from responsibility for their account balance.

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITIES FOR THE PAYMENT OF MY ACCOUNT. When deemed appropriate by PREMIER PHYSICAL THERAPY, a photograph may be taken to document my status.

You agree, in order for us to service our account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

I have read this disclosure and agree that the lender/creditor may contact me as described above.

_____ _____
Patient/Guardian/Responsible Party Date

Worker's Compensation Accounts

The above does not apply for those patients that are considered Worker's Compensation. However, be advised that if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to Premier Physical Therapy. A copy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.
Patient/Guardian _____ Date _____

Notice of Privacy/Confidentiality

As a patient of Premier Physical Therapy, you have a right to the privacy/confidentiality act, and the right to view your medical records according to the regulations of the HIPAA act by the Department of Health and Human Services. Please advise the staff if you have any problems or questions.

____ I have been given notice of our HIPAA Policies. (please initial).

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITIES FOR THE PAYMENT OF MY ACCOUNT. When deemed appropriate by PREMIER PHYSICAL THERAPY, a photograph may be taken to document my status.

_____ _____
Patient/Guardian/Responsible Party Date

_____ _____
Representative/Witness Date

PREMIER
Physical Therapy

PATIENT MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and the gain of your physical abilities is something that everyone in our clinic takes quite seriously.

Because we care so much about you we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore, we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep all your appointments. Write down the time of your visits so that you do not forget.

With the exception of serious emergencies, it is expected that you keep all your appointments. If you need to re-schedule an appointment, we require a 24 hour notice. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferable the very next day.

In an instance of a cancellation without 24 hour notice or no-show to a scheduled appointment, we reserve the right to charge you an $85.00 fee. If we do not hear from you within 24 hours of that missed appointment, we will cancel the following appointments and refrain from scheduling further ones until we hear from you.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order. If you arrive for your appointment fifteen minutes late and we cannot reschedule you to a later appointment, you will be responsible for the $85 fee.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

I have read and understand this policy:

_____ _____

Patient Signature Date

_____ _____

Representative / Witness Date

PREMIER
PHYSICAL•THERAPY

Past Medical History

Patient Name: _____ Age: _____ Date: _____
Date of injury/onset of pain: _____
How did the injury occur/ when did the pain start? _____
_____

Do you have an attorney representing you as a result of this injury/pain? ____Yes___No
Name of Attorney _____

List the current medications (including herbal supplements) that you are taking presently:
_____
_____

Previous Physical Therapy: _____

Past Surgeries and dates: _____
_____

Is there a medical reason that you should not exercise? ___Yes ___No
If Yes, please explain_____

Do you have a past history of:	**Yes**	**No**	**When/How long?**
Alcohol consumption	___	___	_____amount per day Quit Date_____
Smoking	___	___	_____amount per day Quit Date_____
Heart disease	___	___	_____
Heart Surgery	___	___	_____
Heart Palpitations	___	___	_____
High Blood Pressure	___	___	_____
Cancer	___	___	_____
Diabetes	___	___	Type 1_____Type 2_____
Liver Disease	___	___	_____
Osteoarthritis	___	___	_____
Infectious blood disease	___	___	_____
Breathing/Lung Problems	___	___	_____
Known Allergies	___	___	_____
Immunosupression	___	___	_____
Current Infection	___	___	_____
Stroke	___	___	_____
Seizures	___	___	_____
Psychiatric Disorders	___	___	_____
Depression	___	___	_____

What are your goals for rehabilitation? _____
_____

Patient Signature**:** _____**Date:**_____