NEW PATIENT PAPERWORK

PATIENT INFORMATION

_____ **SS#:** _____
First Name **Initial** **Last Name**

Date of Birth: _____/ _____/ _____ **Age**: _____ **Gender**: Male ☐ Female ☐ **Email**: _____

Phone Numbers: (Home) _____ **(Cell)** _____

Home Address (including city, state, and zip code):

Street: _____ **APT #:** _____ **City**: _____ **State**: _____ **Zip**: _____

Emergency Contact: _____ **Phone:** _____ **Relation:** _____

INSURANCE INFORMATION

(If this is a work-related injury you may skip this section.)

Carrier: _____ Policy #: _____ Group #: _____

Policy Holder (if other than self): _____ Date of Birth: _____/_____/ _____

Relationship to Patient: Spouse ☐ Parent/Guardian ☐ Other: _____

Do you have any other medical insurance not listed above? Yes ☐ No ☐ If yes, please fill out information below.

Carrier: _____ Policy #: _____ Group #: _____

Policy Holder (if other than self): _____ Date of Birth: _____/_____/ _____

Relationship to Patient: Spouse ☐ Parent/Guardian ☐ Other: _____

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 gain of your physical abilities is something 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. Except for serious emergencies, it is expected that you keep all your appointments. 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, preferably the very next day.

In an instance of a cancellation when you do not reschedule your appointment within the week, or you no-show to a scheduled appointment, we reserve the right to charge you a $25.00 fee.

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

Kevin Kostka, PT, DPT, PES

Summit/Thrive Physical Therapy

CONSENT TO TREAT

By signing below, I consent to treatment by Summit/Thrive Physical Therapy and their therapists and acknowledge that it is my responsibility to provide SPT/TPT with correct billing information. Treatments could include but are not limited to hands on/manual mobilization, exercise, thermal and non-thermal modalities, dry-needling, and laser therapy. Some treatments may not be billable to my insurance and are cash services.

**All patients under the age of 18 must have a parent/guardian present for their first appointment.*

Signature: _____ Date: _____

FOR OFFICE USE ONLY: INFORMATION INPUT BY: _____

SUMMIT

THRIVE PHYSICAL THERAPY

1. **How did you hear about us?**

- ○ Doctor Referral
- ○ Returning Patient
- ○ Sports Barn
- ○ Internet Search
- ○ Friend/Family: _____
- ○ Social Media
- ○ Summit/Thrive Event
- ○ Insurance
- ○ Saw our sign
- ○ Other: _____

2. **Have you attended**: physical therapy, occupational therapy, speech therapy, or been seen by a chiropractor this year?

- ○ **Yes**. Attended at _____for _____visits.
- ○ **No**

3. May Summit/Thrive Physical Therapy **utilize photographic images, video recording or written information** of you or your child (if patient is a minor), for the purposes of community education, outreach, or marketing of SPT/TPT programs and/or services?

- ○ **Yes**
- ○ **No**

4. **Were you injured at <u>work</u> and pre-approved by your employer under Worker's Compensation Insurance?**

- ○ **Yes**. Injury/accident occurred on: _____/ _____/ _____
  - i. Employer Name: _____
  - ii. Employer Address: _____
  - iii. Employer Phone: _____
  - iv. Position/Title: _____
- ○ **No**

5. **Were you injured in a <u>Motor Vehicle Accident (MVA)</u>?**

- ○ **Yes**. Injury/accident occurred on: _____/ _____/ _____
  - i. **If you have an attorney, please list information below**
    1. **Attorney Name:** _____
    2. **Law Firm:** _____**Phone:** _____
- ○ **No**

<u>Disclaimer</u>: If you have been in a motor vehicle accident and wish to bill your health insurance for services provided, please know that many times we see insurance:

- deny the claim(s) due to another party being liable,
- or insurance may pay initially, only to take back payment when discovering another party should be financially responsible.

**** Please be advised that any denial from your insurance, or any recoupment of payment by your insurance, will be rolled over to patient responsibility. You will be financially responsible for all services rendered if your insurance denies services. ****

SUMMARY OF NOTICE OF PRIVACY PRACTICES

Effective June 30, 2008

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review the full Notice of Privacy Practice (NPP) which is below. If you have any questions about this notice, please ask your Physical Therapist.

We understand that health information about you and your healthcare is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by this practice, whether made by your personal doctor or others working in the office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to health information we keep about you and certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

1. Make sure health information that identifies you is kept confidential
2. Give you this notice of our legal duties and privacy practices with respect to health information about you
3. Follow the terms of the notice that is currently in effect

The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our practice. There are also various other ways in which we may use or disclose your information. Examples: appointment reminders, to allow oversight of the quality of the healthcare we provide as required by subpoena in lawsuits and disputes, various uses as required by law or to avert a serious threat to health or safety.

You have the following rights regarding health information we maintain about you:

1. Right to inspect and copy
2. Right to amend
3. Right to an accounting of disclosures
4. Right to request restrictions
5. Right to request confidential communications
6. Right to paper copy of this notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will furnish you a copy of the current notice if requested. The notice on this page will contain an effective date. In addition, each time you register for treatment or healthcare services, you are welcome to a copy of the current notice in effect. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact your Physical Therapist. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you for the reasons covered by our written authorizations. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provide to you.

Designated Representatives

The following people may call and receive medical information on my behalf.

Name **Relationship**

_____

_____

_____

_____

I acknowledge that I have read and received the Privacy Policy on: _____/ _____/ _____.
(Today's Date)

Signature of Patient/Responsible Party: _____

Relationship to Patient: Self ☐ Parent/Guardian ☐ Other: _____

SUMMIT

THRIVE PHYSICAL THERAPY

MEDICAL HISTORY QUESTIONNAIRE

Patient: _____ Age: _____

Height: _____ Weight: _____ Occupation: _____

1. What are your symptoms? _____
2. When did your symptoms start? _____
3. Are your symptoms the result of an injury? Yes ☐ No ☐

   If yes, briefly describe: _____
4. Have you had surgery in the past year? Yes ☐ No ☐ If yes, surgery date: _____/ _____/ _____
5. Are your symptoms Constant ☐ Intermittent ☐
6. Are you experiencing pain? Yes ☐ No ☐ If yes, is your pain: Sharp ☐ Dull ☐ Achy ☐ Deep ☐ Burning ☐ Throbbing ☐
   a. From 0-10, what is your pain level at rest: _____ During Activities: _____

      (0 being no pain, 10 being unbearable pain)
7. What activities make your symptoms/pain worse? _____

   _____
8. What can you do to relieve your symptoms/pain? _____

   _____
9. Does your condition affect your sleep? Yes ☐ No ☐ If yes, can you go back to sleep? Yes ☐ No ☐
10. How do you feel in the morning? Worse ☐ Better ☐ Stiff ☐ Sore ☐ Fine ☐
11. Have you had any tests since this problem started? X-Ray ☐ MRI ☐ CT Scan ☐ EMG ☐
12. Have you ever had anything similar to this condition? _____
13. Do you exercise? Yes ☐ No ☐ If yes, please describe: _____
14. In the last three months, have you had any of these symptoms (check all that apply):

Fever ☐	Dizziness ☐	Weight Loss ☐
Night Sweats ☐	Vomiting ☐	Abdominal Pain ☐
Fatigue ☐	Shortness of Breath ☐	Fainting ☐
Diarrhea ☐	Leg Cramps ☐	Sweating ☐
Nausea ☐	Headaches ☐	

15. Do you have symptoms before, during, or after eating? Yes ☐ No ☐
16. Are you pregnant? Yes ☐ No ☐
17. Have you had joint replacement? Yes ☐ No ☐
18. Have you been treated for cancer? Yes ☐ No ☐
19. Do you have chest pain? Yes ☐ No ☐
20. Please list all medications you are currently taking or provide the front desk with a copy of your medication list. _____

    _____

Financial Agreement

Thank you for choosing Summit/Thrive PT for your Physical Therapy needs. This financial agreement describes both patient and insurance responsibilities for services rendered. Please read this agreement and sign in the space provided.

INSURANCE

Medical Insurance coverage is a contract between you and your insurance company. We ARE NOT a party to this contract. It is your responsibility to know your insurance benefits including referrals, pre-certifications and required authorizations. As a courtesy to you, Summit/Thrive PT will file claims to your medical insurance company(s) for the services that are provided by our office. If we are given incorrect or incomplete information, you will be billed in full. In order for the claims to be processed correctly, please ensure that the information provided to our office is accurate and current. This may require you to call your insurance company(s) and update your COB (*Coordination of Benefits*). **If there is a change in your insurance information, please notify us immediately.**

We will not be involved in disputes between you and your insurance company(s) regarding deductibles, copayments, coinsurance, covered charges, secondary insurance, usual and customary charges, etc., other than to supply factual information as necessary. **You are responsible for the timely payment of your account, and any outstanding balances or uncovered services.**

PATIENT RESPONSIBILITY & PAYMENT

Payment of copays, coinsurance, and deductibles will be due at the time of service. Our failure to collect these amounts may be a violation of our contract with your insurance company. You are responsible if your insurance denies a claim for any reason.

Copayments: are constant and due at the time your services are rendered.

Coinsurance and deductible payments: vary for each insurance policy, and we can only approximate what your financial responsibility will be.

- We will collect a percentage of what we estimate will be due at the time of service, based on your coverage percentage and collect that amount at the time your services are rendered.
- You will receive a statement or be verbally notified by the front desk when your claims process and we see what balance remains.

PAYMENT OPTIONS

We accept cash, check, and all major debit/credit cards: Visa, Mastercard, Discover, American Express. *Please note that we do not keep cash on hand, and we may not be able to provide change if you do not provide exact payment.*
We understand that financial circumstances vary from patient to patient. If you are unable to pay your due balance in full, please discuss options with the front desk or you may reach our Billing Department at 423-661-3250 to make payment arrangements.

Failure to pay will result in your account being referred to a collection agency, which will affect your credit standing.

I have received this financial agreement and understand that regardless of any insurance coverage I have, I am responsible for payment of my account.

_____	_____	_____
Patient Signature	**Printed Name**	**Date**