Gaspar - Doctors of Physical Therapy

Dear Patient,

We are pleased that you have chosen Gaspar - Doctors of Physical Therapy for your physical therapy needs.

Please take time to fill these forms out completely **prior** to your scheduled appointment so that the therapist can spend the full appointment with you.

On the day of your appointment, please bring:

- Completed forms
- Insurance card(s)
- Prescription for physical therapy with diagnosis

PLEASE NOTE: If you have an insurance plan that requires a referral/authorization to see a specialist (such as HealthNet HMO/POS, Blue Cross HMO, Blue Shield HMO, Pacificare HMO/POS, etc.), please contact your primary care physician or medical group to obtain a referral prior to your appointment date.

Please arrive 5-10 minutes early to allow sufficient time for check-in.

Sincerely,

Gaspar - Doctors of Physical Therapy, APC

Please tell us how you found us:
(Please check all that apply)

- ❑ A movie theater ad I saw
- ❑ Email newsletter
- ❑ One of our physical therapists
- ❑ A family member
- ❑ A friend
- ❑ I was a previous patient
- ❑ My insurance company referred me
- ❑ I found you on the internet
- ❑ My doctor referred me

Doctors of Physical Therapy

Patient Information

******Please present your insurance card(s) for copying.******

Patient Name:	**Date of Birth:**	**Age:**	**Sex:** **M F**
Social Security Number:	**Employment Status:** **Emp Unemp Retired Student**	**Marital Status:** **Single Married Other**	
Address:	**City, State, Zip**		
Home Phone: OK to leave message? Yes No	**Work/Cell Phone:** OK to leave message? Yes No	**Employer:**	
Referring MD:	**Primary Care MD:**		
Financial Party:(if other than patient)	**Relationship:**	**Social Security Number:**	**Date of Birth:**
Home Phone:	**Work Phone:**	**Employer:**	
Emergency Contact:	**Relationship:**	**Home Phone:**	
Address:		**Work Phone:**	

Cancellation Policy and Consent to Treat

We at Doctors of Physical Therapy want to provide the best possible care for our patients and attending your scheduled appointments is a necessary part of the treatment process. If there is not notice of cancellation 24 hours before the scheduled appointment, **a $40 cancellation charge will be billed directly to the patient for each cancellation.**
By signing below, you acknowledge that you have read, understood and agree to abide by our cancellation policy as described. You also acknowledge the above patient information is correct to the best of your knowledge.

I grant permission for the staff of Doctors of Physical Therapy, APC, to perform the procedures as prescribed by my physician including a physical therapy evaluation. During this evaluation, the nature of the procedures that will be performed as well as the potential risks of care will be explained to me.

If I become ill while undergoing treatment, I give permission to the staff to administer treatments which they consider necessary to my well-being. **My signature below indicates that I understand and give consent to be treated as explained above.**

Patient Signature:	**Guardian's Signature: (If patient is <18 years old)**	**Date:**

Doctors of Physical Therapy

Patient Medical History Form – For Clinic Use ONLY

Name:	Age:	Current Concern/Problem:	**Date of Onset:**

I. Have you ever been diagnosed with any of the following conditions? FILL IN THE APPROPRIATE CIRCLES.

1. Cancer:	Yes ☐	Type(s), include date of diagnosis:

2. Infection:	Yes	No
Chronic Urinary Tract/Kidney Infection	☐	☐
Pneumonia	☐	☐
Bone/Joint Infection	☐	☐
Viral Conditions:	☐	☐
Other Infection: (Please List)	☐	☐
1.		

3. Cardiovascular:	Yes	No
Heart Disease:	☐	☐
Deep Venous Thrombosis (DVT):	☐	☐
Arterial Blockage of the Legs	☐	☐
High Blood Pressure:	☐	☐
Stroke/TIA	☐	☐
Other:		

4. General Medical Conditions:	Yes	No
Rheumatologic Disorders:	☐	☐
Lung Disorders:	☐	☐
Liver/Kidney Conditions:	☐	☐
Gastrointestinal Disorders:	☐	☐
Neurological Disorders:	☐	☐
Anemia/Blood Disorders:	☐	☐
Thyroid Conditions:	☐	☐
Gout:	☐	☐
Diabetes:	☐	☐
Dermatologic Conditions:	☐	☐

4. General Medical Conditions:	Yes	No
Osteoarthritis: (Wear-and-Tear Arthritis)	☐	☐
Osteoporosis/Osteopenia:	☐	☐
Dizziness or falls:	☐	☐
Depression:	☐	☐
Bowel/Bladder Incontinence:	☐	☐
Headaches: (more than 1 per week)	☐	☐
Vision or hearing difficulty	☐	☐
Immunologic/Allergy Conditions:	☐	☐
Genitourinary/Gynecologic Conditions	☐	☐
Other conditions:		

II. Please List All Medications Including Frequency and Dosage: (both over-the-counter and Prescribed)

	Frequency	Dosage		Frequency	Dosage
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

III. Surgeries and/or Hospitalizations:		**IV. Other Current Conditions:**	Yes	
1.	Date:	1. Recent, unplanned weight loss?	☐	☐
2.	Date:	2. Unexplained night pain?	☐	☐
3.	Date:	3. Fevers or night sweats?	☐	☐
4.	Date:	4. Nausea/Vomiting?	☐	☐
5.	Date:	5. Unexplained weakness or fatigue?	☐	☐

V. Health-Related Habits

Smoking	Yes	No		Yes	No		
If yes, < 1 pack/day?	☐	☐	Do you have a Pacemaker?	☐	☐		
If yes, > 1 pack /day?	☐	☐	Are you Latex Sensitive?	☐	☐		
Ice Sensitive?	☐	☐	**Heat Sensitive?**	☐	☐		
Previous experience with physical therapy?	☐	☐	**How many falls have you had in the last year?** _____			**Are you currently pregnant?**_____	

I affirm that the above information is accurate and true.

Patient Signature_____ **Date**_____ **Therapist Review (Initials)** _____

**Adapted from: Boissonnault WG, Badke MB. Collecting health history information: The accuracy of a patient self administered Questionnaire in an orthopedic outpatient setting. *Phys Ther*. 2005; 85(6):531-543.

Doctors of Physical Therapy

Office Payment Policy

It is the policy of Doctors of Physical Therapy, APC. (DPT) that payment is due at the time of service unless other financial arrangements are made in advance. **We require all patients to pay their deductible, co-pay and/or co-insurance payment at the beginning of each visit.** The Office Manager at your location will explain this information to you prior to your first visit. At the conclusion of your therapy with DPT you may be billed for any outstanding balances. If there is a positive balance or credit, you will be provided a refund promptly.

If you are covered by health insurance with physical therapy benefits, we will be happy to bill your insurance. Please provide your insurance information to the office manager and we will verify your coverage as a courtesy. Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by a physician does not necessarily guarantee that your insurance will cover our services. **Please remember that you are 100% responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment. You are required to bring in your prescription from your physician, as well as your insurance card prior to being seen. All patient paperwork must be filled out completely, as well. Failure to do so will result in DPT charging you as a cash paying patient.** Therefore, we highly recommend you also contact your insurance carrier and check into your coverage for physical therapy. Do not assume that you will not owe anything if you have more than one insurance policy. If you need special arrangements to be made, please discuss this with the business manager before starting your treatments.

Please initial your payment method and sign below that you have read, understand, and agree with all of the information on this page:

_____ 1. **PRIVATE HEALTH INSURANCE (PPO)**: Some insurance plans require authorization or a referral from your primary physician. Most insurance plans have a patient responsibility (deductible or amount paid by the patient before the insurance policy begins payment for services) and/or a co-pay (set dollar amount per visit) or coinsurance (a percent of the allowed charges). **Deductibles, copay, and coinsurances, are due at the time of service.** Should your insurance deny coverage, we will bill you for the outstanding amount.

_____ 2. **HMO Insurance**: Authorization from your insurance must be obtained prior to treatment. Any copay or coinsurance is due at the time of treatment. If your HMO plan also has a Point of Service option you are using, please be sure you understand the difference in your Point of Service coverage verses your HMO coverage.

_____ 3**. MEDICARE**: DPT is a certified Medicare provider. Medi-Gap insurance covers the patient portion due until your Medicare benefits are exhausted. Some secondary insurance plans cover the portion due and services after Medicare benefits are exhausted, but not always. All Medicare covered patients are subject to an annual deductible and a cap to physical therapy benefits.

_____ 4. **Secondary Medicare Insurance Provider:** _____

_____ 5. **NO INSURANCE (CASH)**: If you do not have insurance you may be eligible for an administrative discount if payment is received at time of service. Please notify the office staff that you do not have insurance so that a payment plan can be discussed.

_____ 6. **WORKER'S COMPENSATION CLAIMS**: Authorization from your insurance adjuster is required before you can begin treatment. Please provide the office manager with the name and phone number of your adjuster, the date of your injury and your claim number, and any other pertinent information.

_____ 7. **OTHER**: Please list the other type of payment: _____

** Doctors of Physical Therapy, APC. accepts Liens and 3rd Party Payments upon approval by our business manager only!

I have reviewed this office payment policy and discussed it with the office manager. All my questions have been answered to my satisfaction and I understand all the information that has been explained to me.

Patient Signature:	**Guardian's Signature: (If patient is <18 years old)**	**Date:**

Doctors of Physical Therapy

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

DOCTORS of PHYSICAL THERAPY'S LEGAL DUTY

Doctors of Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Doctors of Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Doctors of Physical Therapy may also use or disclose your personal health information without prior authorization for emergencies, research studies, auditing purposes, and public health/statistical purposes. We also provide information when required by law. In any other situation, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Doctors of Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances.

CONCERNS AND COMPLAINTS

If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Privacy Officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services.

For further information on our health information practices or if you have a complaint, please contact the following person:

****Please retain this copy for your records****

Doctors of Physical Therapy

ACKNOWLEDGEMENT OF PATIENT INFORMATION PRACTICES

I have read and fully understand Doctors of Physical Therapy's Notice of Patient Information Practices. I understand that Doctors of Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Doctors of Physical Therapy's Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____

Patient Name

_____

Signature (Guardian if patient is a minor)

_____

Date