



LAFAYETTE PHYSICAL THERAPY, INC.

Patient Information

Last Name		First Name		MI	Sex M F	Marital Status	
Home Phone		Cell/Alternate		SSN		DOB	
AGE		Address (No P.O. boxes please)		City		State	
Zip		Emergency Contact Person		Relation		Phone	
Employer		Occupation		Work Phone			
Employer Address		City		State		Zip	
Guarantor Name		Employer		DOB		Phone	
Referring Doctor		Who can we thank for referring you?					
Automated Appt. Reminders: Please select one phone number or e-mail to receive appt. reminder notifications on							
[] Home [] Cell/Alternate [] Work [] Email: _____ [] No reminder							

OFFICE USE ONLY:
Our front desk will fill this portion out upon your arrival.

Insurance: *The following benefits were quoted to us by your insurance company. This is not a guarantee of payment by your insurance. You are responsible for knowing your benefits.*

_____ Patient is eligible for benefits: Effective Date: _____ to _____

_____ Prior authorization is required

_____ Month to month coverage

_____ Coverage is based on medical necessity

_____ Rx required

Benefits Information:

_____ Max \$ Per year, \$ _____ remaining

_____ Max visits per year, _____ visits used, _____ remaining

_____ Insurance pays, _____ patient co-insurance

_____ Total deductible, _____ deductible met, collect _____ per visit toward deductible*↴

_____ Out of pocket, _____ out of pocket met

_____ Copayment: _____

_____ Combined Coverage: _____

*The amount collected toward your deductible each visit is LESS than the actual amount we bill for each visit. You will receive a bill for the remaining balance once your insurance processes your claims.

Lafayette Physical Therapy, Inc. will bill your primary insurance as a courtesy to you, please remember co-payments and deductibles are due at time of each visit and co-insurances will be billed to you after we receive confirmation from your insurance. **Account balances are due upon receipt of a statement.** I request that payment of all insurance or authorized medical benefits be made directly to Lafayette Physical Therapy, Inc. Should my insurance pay me directly, I agree to forward the payment to Lafayette Physical Therapy, Inc. I authorize the release of any medical information necessary to process this claim, including the release of medical information to the Health Care Financing Administration and its agents. I understand that any charges not covered by my insurance will be my responsibility. I attest that all information I have provided to Lafayette Physical Therapy, Inc. regarding my condition, personal, and insurance information, is true and correct. I have read and understand the above information. A photocopy of this agreement shall be as valid as the original.

ALERT: Please sign AFTER insurance and benefits info is entered by our front office.

{ _____
Patient/Guarantor Signature _____ Date

Lafayette Physical Therapy, Inc.

NOTICE OF PATIENT INFORMATION PRACTICES

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

USES AND DISCLOSURES OF HEALTH INFORMATION

Lafayette Physical Therapy, Inc. 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, Lafayette Physical Therapy, Inc. 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.

Lafayette Physical Therapy, Inc. may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for other health related benefits that could be of interest to you.

In any other situation, Lafayette Physical Therapy, Inc.'s 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.

Lafayette Physical Therapy, Inc. 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 do 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. Lafayette Physical Therapy, Inc. will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Lafayette Physical Therapy, Inc. 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 or if you have a complaint, please contact the Clinic Director, Valerie Watase at (925) 284-6150. You may also send a written complaint to the U.S. Department of Health and Human Services.

I have read and fully understand Lafayette Physical Therapy, Inc.'s Notice of Information Practices. I understand that Lafayette Physical Therapy, Inc. may use or disclose my personal health information for the purpose 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 also understand that Lafayette Physical Therapy, Inc. will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Lafayette Physical Therapy, Inc. Notice of Information Practices. I understand that I have the right to revoke this consent by notifying Lafayette Physical Therapy, Inc. in writing at any time.

Print Patient Name

Patient Signature

Date

LAFAYETTE PHYSICAL THERAPY INC
Private Insurance Billing Policy

1. **CO-PAYMENTS:** Due at the time of each appointment.
2. **DEDUCTIBLES and COINSURANCE:** We request that you pay a reasonable amount towards your deductible and/or coinsurance. Although we will collect towards your deductibles and co-insurance, please understand that this may not cover your total share of cost and that you may be billed at a later date.
3. **ACCOUNT RESPONSIBILITIES:** The patient remains responsible for accounts not covered under insurance, including deductibles and co-insurance amounts. We will bill your Insurance as a courtesy; however, please be advised if your insurance fails to pay within 90 days, your account balance will then be your responsibility. In the event that your insurance refuses to pay, you will be required to pay your balance in full. Please initial that you have read and understand this policy. _____
4. **RESPONSIBILITY OF COVERAGE:** It is the patient's responsibility to know their medical insurance coverage including: deductibles, co-payments, prescriptions, limits of visits, etc. Please verify with your insurance company what your insurance covers.
5. **PRE-AUTHORIZATION:** Required by many insurance companies. It is the patient's responsibility to inform this office if preauthorization is required. Please secure all pertinent papers, if needed.
6. **NO SHOW OR CANCELLATION POLICY:** Lafayette Physical Therapy Inc. reserves the right to charge a \$65.00 fee for no show or same day cancellations (cancellations with less than a 24 hour notice). When cancelling a Monday appointment we require notice by 3pm the Friday before. **Lafayette Physical Therapy reserves the right to discharge patients who fail to attend their scheduled appointments.** Workers Compensation patients cannot be charged for missed visits, however, we are required to report them to your case manager and this may affect your claim.
7. **OVERDUE ACCOUNTS:** Accounts 60 days or more overdue may be assigned to Transworld Systems Collection Agency. Any accounts assigned to this third party collections company will be subject to a \$25 processing fee. Lafayette Physical Therapy, Inc. reserves the right to charge an interest fee of 1.5% for unpaid balances after 30 days.
8. **INSURANCE CHANGES:** It is your responsibility to notify our office of any changes to your insurance.

Thank you for your cooperation.

I have read and understand the above statements.

Patient Signature

Date

Lafayette Physical Therapy, Inc.

To Our Patients Regarding Cancellations 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 have 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 therapist's instructions and we will be able to help you achieve your goals in treatment.

- **We require a 24 hour notice in the event of a cancellation.** For Monday appointments we require notice by **3pm on the Friday before**. 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.)
- **There is a \$65 charge for cancellations without proper notice.** This charge will not be covered by insurance and will have to be paid by you personally.
- For Worker's Compensation and Personal Injury patients: documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim. State law prohibits charging Work Comp patients for missed visits.
- If you rearrange your appointments you may need to see a therapist other than the one who normally treats you. All of our therapists are experienced professionals, and they will familiarize themselves with your condition, so you will be in good hands. You will return to your original therapist on your next regularly scheduled visit. **Lafayette Physical Therapy reserves the right to discharge patients who fail to attend their scheduled appointments.**
- Please understand that your pain could increase and decrease as your course of treatment progresses before the completion of your treatment. Either condition may seem to be a reason to not come in: a) you are feeling worse and think the treatment is not working or b) You are feeling better and it's a great day for wind-surfing. Neither of these conditions is a legitimate reason to not come: a) If you are in pain, come in and let the therapist work with you to reduce it. 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, educate you so you won't re-injure yourself, etc.

When you do not show up as scheduled, three people are hurt: You, because you do not get the treatment you need as prescribed by the doctor and/or Physical Therapist; The Therapist who now has a space in their schedule since the time was reserved for you personally; And another patient who could have been scheduled for treatment if you had given proper notice.

Thank you for your cooperation. We are looking forward to working with you.

Patient Signature

Date

Interviewer Signature

Date

Lafayette Physical Therapy

Patient History and Pain Questionnaire

Name: _____ Date: _____ Age: _____

1) Have you ever had **any** of the following **problems** or **conditions**?

	Yes Current	Yes Past	No Never		Yes Current	Yes Past	No Never
High Blood Pressure	_____	_____	_____	Osteoporosis	_____	_____	_____
Heart/Circulation Disorders	_____	_____	_____	Diabetes	_____	_____	_____
Pacemaker	_____	_____	_____	Dizziness	_____	_____	_____
Immune Deficiency Disease	_____	_____	_____	Headaches	_____	_____	_____
Seizures	_____	_____	_____	Vision	_____	_____	_____
Numbness or Tingling	_____	_____	_____	Nausea	_____	_____	_____
Bowel or Bladder Changes	_____	_____	_____	Cancer	_____	_____	_____
Broken Bones	_____	_____	_____	Depression	_____	_____	_____
Metal pins/plates post fracture	_____	_____	_____	Anxiety	_____	_____	_____
Arthritis	_____	_____	_____	Allergies	_____	_____	_____
Neurologic Disorders	_____	_____	_____	To what:			
Please Specify							

If **YES** to any of the above, please explain:

2) Have you ever had **Physical Therapy** treatment before? Yes No

If yes, when and what was it for? _____

3) Please list **ALL surgical procedures** you have had in the past and give the dates if possible:

4) Please list **recent diagnostic studies (X-Ray, MRI, CAT, etc.)** and give dates if possible:

5) If female, are you Pregnant? Yes No

6) List any **medications** you are now taking. (Prescribed and over the counter: provide list if available)

7) Have you ever taken **steroids (ie: asthma inhalers)** for an extended period of time? Yes No

8) Have you ever taken **anti-coagulants (ie: Aspirin)** for an extended period of time? Yes No

PLEASE FILL OUT BACK PAGE

9) Have you had an **unusual weight loss or gain** recently? Yes No

10) Briefly describe the **history of your present injury, accident, or illness:** **Date of Injury:** _____

11) What **aggravates** your pain?

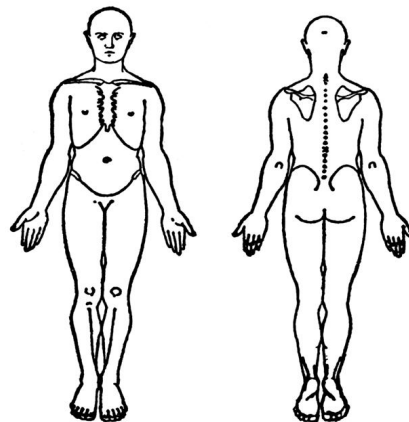
Bending	_____	Twisting	_____	Reaching	_____
Sitting	_____	Standing	_____	Walking	_____
Driving	_____	Other:	_____		

12) What **eases** your pain?

Changing Positions	_____	Stretching	_____	Heat	_____
No Movement	_____	Lying Down	_____	Cold	_____
Walking	_____	Standing	_____	Massage	_____
Other:	_____				

13) For the current condition, on a scale of **0 to 10**
(0 Being no pain, and 10 being worst pain ever).

What is your: Pain level **today**: _____
Pain at its **worst**: _____
Pain at its **best**: _____



14) Please **indicate** on the body chart the **area of your problem(s) and/or your discomfort:**

15) Have you **fallen** in the past year? _____ Yes, _____ times. _____ No (If yes please complete #16)

Please explain the circumstances surrounding the fall(s) that you are reporting above.

16) Did you sustain any **injuries** from the fall(s)?

Patient Signature

Date