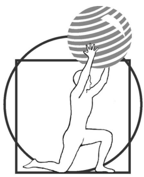


LAFAYETTE PHYSICAL THERAPY, INC.

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 RESPONSIBILITES:** 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.

Cancellation Policy
WORKERS COMPENSATION

In order for Lafayette Physical Therapy to continue to provide the best Physical Therapy available, **we require a 24 hour notice in the event of a cancellation. For Monday appointments require notification 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 in two sequential days.) This advance notice allows us to schedule another patient who may need an appointment so that your appointment time is not completely lost.

- **The first occurrence**: If you *NO SHOW* or *CANCEL* without 24 hours notice our office is required to alert all involved parties and it may affect the course of your treatment.
  - Documentation of any missed appointment is sent to your Case Manager and your Primary Physician. This may jeopardize your claim.
  - 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.

- **The second occurrence:** If you no show or cancel without adequate notice a second time we will be required to put you on same-day appointment scheduling only.
  - You will need to call our office on the days you wish to be seen to see if there are any available drop-in appointments.
  - You will need to see a therapist who is available during the day and time you call in. All of our therapists are experienced professionals, and they will familiarize themselves with your condition, so you will be in good hands.
  - Additional documentation of any missed appointments is sent to your Case Manager and your Primary Physician. This may jeopardize your claim.

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.

Please understand that your pain could increase and decrease over the course of your treatment. You may feel that feeling better or feeling worse is a reason to not come in for treatment, however, neither of these conditions is a legitimate reason to not come. If you are in pain, come in and let the therapist work with you to reduce it. If you are out of pain, now is the time that we can really work on the underlying <u>causes</u> of your problem and educate you in injury prevention.

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

______________________________	______________________________	____________
Print Patient Name	Patient Signature	Date

OFFICE USE ONLY:

Cancellation/No-Show Log:

		SAME DAY ONLY: [ ]

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?

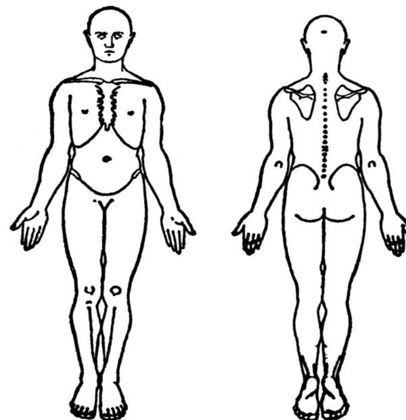
Changing Positions	_____	Stretching	_____	Heat	_____
No Movement	_____	Lying Down	_____	Cold	_____
Walking	_____	Standing	_____	Massage	_____

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