Patient Name: ___________________________ DOB: ____________

Medical History

| | Y | N | | Y | N | | Y | N |
|---|---|---|---|---|---|---|---|---|
| Allergies | | | Diabetes | | | Multiple Sclerosis | | |
| Anemia | | | Shortness of Breath | | | Muscular Disease | | |
| Arthritis | | | Dizzy Spells | | | Osteoporosis | | |
| Asthma | | | Emphysema/Bronchitis | | | Parkinson's Disease | | |
| Auto-immune Disorder | | | Fibromyalgia | | | Rheumatoid Arthritis | | |
| Cancer | | | Fractures | | | Seizures | | |
| Cardiac Conditions | | | Headaches | | | Strokes | | |
| Cardiac Pacemaker | | | High/Low Blood Pressure | | | | | |
| Circulation Problems | | | Metal Implants | | | | | |
| Currently Pregnant | | | Rapid Heartbeats | | | | | |

| Question | Y | N |
|---|---|---|
| Have you recently recovered from an illness (e.g. cold, flu, sinus infection)? | | |
| Has a medical doctor informed you that you should not participate in an exercise program or physical activity? | | |
| Have you recently had a general health check-up from your physician? | | |
| Other than your reason for being here today, are you in good health? | | |
| Is there any other health or medical information we should know about that may affect your treatment? | | |

Please list medications you are currently taking (you may bring a list with you instead):

| Drug Name | Dosage | Frequency | Reason Taking |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

List any operations you have had in the past year and/or any operation you have ever had that pertain to the reason you are being seen today:

Please list allergies:

**For Medicare Recipients Only:** ***Medicare will not pay for outpatient physical therapy if you are enrolled in a Home Health program.*** Home Health services include, but are not limited to, intermittent skilled nursing care (other than just drawing blood); Physical therapy, speech-language pathology, or continued occupational therapy services; medical social services; part-time or intermittent home health aide services; medical supplies for use at home; durable medical equipment; injectable osteoporosis drugs; or any other services, paid for by Medicare, that are performed in your home.

Are you ***currently*** having any Home Health Services that are being billed to Medicare: _____ Yes _____ No

Have you had *any* Home Health Services *this year* that were billed to Medicare: _____ Yes _____ No

**Have you had any physical, occupational, speech therapy or chiropractic services *THIS CURRENT BENEFIT PLAN YEAR*?** _____ Yes _____ No

If "Yes" when/where:

Signature: ______________________________________________________ Date: ___________________

Consent to Treat

**AUTHORITY TO EVALUATE AND PERFORM TREATMENT**—I grant permission to HPT to perform treatment of physical therapy as deemed necessary by a Licensed Physical Therapist.

**AUTHORITY TO RELEASE INFORMATION**—I grant permission to HPT to release information concerning my physical condition to my insurance, attorney at law (with a current signed release), and any health care facility I may be transferred to or any health care facility from which I was referred.

**AGREEMENT AND ASSIGNMENT**—This date I have a contract with HPT Physical Therapy Specialists, Inc., 2240 5th Avenue, Huntington, WV 25703, for the furnishing of services rendered or to be rendered. I hereby direct my insurance to pay by check or electronic funds transfer payable to HPT without payment to me. I assign to HPT the rights to all present and future benefits due under my existing policy or policies of insurance.

**VERIFICATION OF THIRD-PARTY BENEFITS**—HPT does not accept third-party claims. We will consider your special circumstance, but please have other payment sources available.

**PAYMENT POLICY**—As a courtesy to you, HPT will file your claim to your insurance carrier, but you must have the proper current insurance ID cards, a driver's license or state-issued photo ID, and doctor's order for physical therapy (if required by your insurance company) at the time of your appointment. We will verify your eligibility with your insurance company prior to your appointment whenever possible, and we encourage you to also contact your insurance company for verification.

If deductibles are not met you will be expected to pay at the time of service 100% of the charges at each visit until your deductible has been satisfied. If your insurance company has not paid the balance of charges within 60 days of your visit, HPT will require the balance from you. You are responsible for contacting your insurance carrier if payment is not made.

Claims rejected by Worker's Compensation will be your responsibility. The balance due will be your responsibility. You must provide us with the correct claim number and date of injury for proper billing. You will also be asked to provide your medical insurance information at the time of registration to bill in case the claim is denied.

If unusual circumstances make you unable to meet our credit terms, call to discuss this matter with our billing department. We want you to keep your account in good standing. You authorize HPT the right to obtain a credit check if necessary. If your account becomes past due at any time for any reason, you agree to pay, for each month that it is past due, an additional $25 per month.

**ADVANCE BENEFICIARY NOTICE OF NON-COVERAGE (ABN)**—Your insurance company may deny payment of certain items or services due to the items or services not meeting their medical necessity requirements. They may also deny services that exceed the limits of your policy. You are responsible for payment of the non-covered items or services if you elect to receive them. If your visits exceed the limits of your policy, you are fully responsible for the balance due. HPT does not bill your insurance company for supplies that cost $50 or less; you are responsible for payment of these supplies on the day that you receive them. HPT will bill supplies that cost more than $50 to your insurance company, but you are still expected to pay for them on the day that you receive them; you will be refunded should the insurance company reimburse us.

**I AGREE THAT I AM RESPONSIBLE FOR PAYMENT OF THE TOTAL BILL INCURRED AS A RESULT OF SERVICES RECEIVED. I AGREE TO PAY ANYTHING AND EVERYTHING THAT THE INSURANCE DOES NOT COVER.**

I, the undersigned, have read and understand the entire Consent to Treat form. I hereby agree to the terms therein.

____________________________________________ ________________________

Patient/Guardian Signature Date

**Cancellation, No-Show and Late Arrival Policy**

HPT Strives to provide quality individualized care in a timely manner to you and the rest of our patients. Late cancellations, no-shows and late arrivals inconvenience the staff and other patients in need of care. In order to render excellent care, we have had to implement a Cancellation/No-Show/Late Arrival Policy. This policy enables us to better utilize available appointments for our patients.

**Cancellations**—We ask that you notify our office at least 24 hours prior to your appointment time in the event of a cancellation. This gives us the opportunity to reallocate your appointment time to another patient. While we understand that it is not always possible to give 24-hour notice, anything less than that for a non-emergency cancellation does not give us ample time to reschedule another patient. **(Initial ________)**

**No-Shows**—A "no-show" occurs when you fail to keep your scheduled appointment and you did not contact our office to cancel it. Each time a patient misses an appointment without providing adequate notification, another patient is prevented from receiving care. **(Initial ________)**

**Late Arrivals**—Coming in later than your scheduled appointment time may cause you to not receive the individualized care that you deserve because your therapist may have another patient here who did arrive on time for his appointment. It is important that you come in on time so that your therapist can spend time with you as well as the other patients on the schedule. While we understand that situations may arise preventing patients from arriving to their scheduled appointment on time, HPT reserves the right to reschedule your appointment if you are more than 15 minutes late for your appointment. **(Initial ________)**

- Your therapist and your physician have developed a plan of care for your treatment that specifies you are to be seen a certain number of times per week. If you cancel your appointment and do not reschedule it for another day within that same week (when possible), or you fail to show up for your scheduled appointments, then you jeopardize the positive outcome of your treatment. **(Initial ________)**
- Our staff will contact you in an attempt to reschedule your missed appointments. Chronic cases of cancellations and no-shows, as well as failed attempts to reschedule missed appointments, will result in notification to your referring physician and discharge from care. If you are an injured worker, your Workers Compensation claim manager will also be notified. **(Initial ________)**

By my signature below, I attest that I have read and understand the Cancellation and No Show Policies of the practice and I agree to the terms.

______________________________________________ ______________________

Name Date

***Acknowledgement of Receipt of NOPP***

This is to serve as acknowledgement that I have been asked to receive a copy of the Notice of Privacy Practices (NOPP) from HPT Physical Therapy Specialists. I have been informed that HPT's NOPP is visibly displayed in the lobby waiting area, and I may request and receive a printed copy at any time. (**Initial ________**)

***Authorization to discuss Protected Health Information (PHI) with a designated representative***

This is also to serve as acknowledgement that I authorize HPT Physical Therapy Specialists to disclose or discuss my health information as well as financial responsibility to HPT with the following persons:

- ❖ If the patient is 18 years of age, he/she is considered a legal adult even if covered under parent's insurance, and we have to obtain permission to speak with the parent or guardian regarding the patient.
- ❖ **If the patient is under the age of 18, we *do not* need permission to disclose or discuss information with parents.**
- ❖ If the patient is female *under the age of 18 and is pregnant*, we have to obtain permission to speak with the parent or guardian regarding the patient.
- ❖ This authorization is outside of the scope of normal business function; by signing the Consent to Treat, you have given permission to speak with your insurance, claim manager, referring physician, etc. You do not need to list them here.
- ❖ ***Please write "N/A" if there is no one you wish to authorize HPT to discuss PHI with.***

Spouse ______________________________________________

Children ______________________________________________________________________

Parent(s) ______________________________________________________________________

Other ______________________________________________________________________

***Communication Restrictions or special instructions***

Please advise us of ***any*** restrictions or special instructions regarding our communication with you or with a representative listed above. ***Please write "N/A" if there are no restrictions or special instructions regarding communication.***

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

***Authorization to leave messages***

I authorize HPT to leave a message on my answering machine, voice mail or with any person answering my phone.
☐ Yes ☐ No

Patient's Name & DOB (***Please print***): ____________________________________________________________

Personal representative & relationship (if patient is unable to sign, is under age, or unable to understand):

__________________________________________________________________

Signature: _______________________________________________ Date: ______________________