Comprehensive Orthopedic Rehabilitation of Edmond

CORE Physical Therapy

FINANCIAL AGREEMENT

I understand and agree that I am totally responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I understand that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am primarily responsible for all charges regardless of my existing medical coverage. In the event that my insurance company forwards payment directly to me, instead of Core Physical Therapy, I will immediately deliver such payment directly to Core Physical Therapy. I understand and agree that if it becomes necessary to commence legal action for the collection of any outstanding charges on my account, I will be responsible for any costs and or court fees, in addition to the outstanding balance. There will be a 1.5% late charge of any balance 90 days or over; once the insurance company pays. *Please initial* _____.

I hereby give authorization for payment of insurance benefits to be made directly to Core Physical Therapy for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of the agreement is as valid as the original.

_____ Date _____/_____/_____

Signature *(Parent or guardian signature if patient is a minor)*

APPOINTMENT POLICY

I understand that my doctor has prescribed therapy for me and that physical therapy is an ongoing process which requires regular attendance to be optimally effective.

APPOINTMENTS

Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival of greater time than 15 minutes may result in a shortened treatment or cancellation. We require advance notice of 24 hours of cancellation. Failure to show for an appointment or cancellation without sufficient notice may be subject to a $25.00 charge.

CO-PAYMENT POLICY

Patients that carry health care insurance should remember that some policies require a copayment for each visit. Consequently it is your responsibility as defined by your policy to make these copayments. Also important is that you are responsible for any and all supplies, such as braces and exercise equipment, which are provided to you and are not covered by your particular plan. I understand and agree that I am solely responsible for all copayments and charges incurred which are not covered under my health care plan. I also authorize the release of any medical information necessary to process this claim.

AUTHORIZATION FOR TREATMENT

I hereby consent to and authorize all therapy treatments, which in conjunction with the judgments of the attending physician may be considered necessary or advisable for the diagnosis or treatment of the above named patient at Core Physical Therapy. I realize that I am a integral part of the rehabilitation process and will be sufficiently educated about treatment and alternatives before they are performed. *Please initial* _____.

_____ Date _____/_____/_____

Signature *(Parent or guardian signature if patient is a minor)*

Patient Name _____

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Date: _____

PATIENT INFORMATION

First Name: _____ Middle: _____Last: _____ ☐Male ☐ Female

Address: _____City: _____State: _____Zip: _____Marital Status:_____

Phone: _____Date of Birth: _____Age:_____ SSN: _____Email_____

Employer: _____Work Phone: _____ Cell Phone_____

Address: _____City: _____State: _____Zip: _____

Emergency Contact: _____Phone: _____

PCP/Referring Physician: _____UPIN #: _____Phone: _____

Address: _____City: _____State: _____Zip: _____

Date last seen by attending/referring physician_____/_____/_____

WORKER'S COMPENSATION INSURANCE INFORMATION

Name of Worker's Comp Carrier: _____Phone: _____

Address: _____ City: _____ State: _____Zip: _____

Employer at the time of Injury: _____Phone: _____

Employer's Address: _____City: _____State: _____ Zip: _____

Is Pre-authorization or referral required? ☐Yes ☐No Auth #: _____ # of Visits: _____

Worker's Comp Claim #: _____DOI: _____

Claims Adjuster: _____Phone: _____Ext: _____

Have you ever had Physical Therapy for this injury? ☐Yes ☐No If yes, where: _____

Is this case currently involved in litigation? ☐Yes ☐No

Is there an Attorney involved? ☐Yes ☐No

If yes, Attorney's Name: _____Phone: _____Ext: _____

Attorney Address: _____ City: _____State: _____ Zip: _____

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Patient's Authorization to Disclose Medical Records

I, _____, authorize **Core Physical Therapy, Inc.** to release medical information to be used on my behalf to the following:.

Referring Physician's Name: _____

Your Insurance Company _____

Other Physician/Other Insurance: _____

Please ***initial*** the following to authorize:

_____ I consent to treatment by a physical therapist.

_____ I specifically authorize the release of physical therapy records and any physician's orders for therapy, to the parties mentioned above.

_____ I authorize Core Physical Therapy, Inc. to bill my insurance company and furnish information to them concerning my treatments.

_____ I assign to Core Physical Therapy all payments for services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

_____ I understand that I will be billed for any appointments canceled with less than 24 hours notice.

_____ I have been informed that this office's ***Notice of Privacy Practices (HIPPA)*** is available upon request and is on display to review on anytime. I can obtain a copy by request.

May we leave the following information on your answering machine at home or work? (***Please Initial***)
Appointment/Schedule confirmations with date and time? Yes_____ No_____
Financial Information? Yes_____ No_____

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire one year from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Signature of Patient _____

Date _____

(Parent or Guardian if applicable) _____

Date _____

For Office Use
We attempted to obtain a written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:
____Individual refused to sign
____Communication barriers prohibited obtaining the acknowledgment
____An emergency situation prevented us from obtaining acknowledgment
____Other (Please Specify) _____

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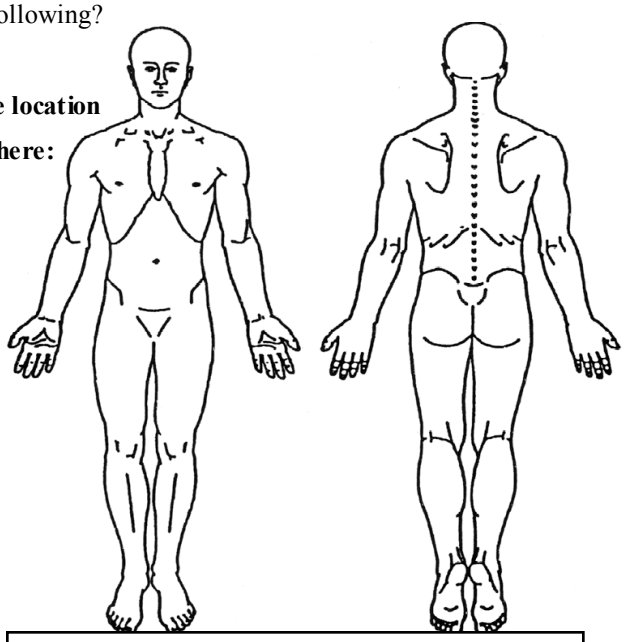
Have you ever had any of the following?

	Yes	No
High Blood Pressure	☐	☐
Cardiac Conditions	☐	☐
Metal Implants	☐	☐
Nervous Disorders	☐	☐
Pacemaker	☐	☐
Seizures	☐	☐
Dizzy Spells	☐	☐
Diabetes	☐	☐
Allergies	☐	☐
Fractures	☐	☐
Stroke	☐	☐
Arthritis	☐	☐
Vision Problems	☐	☐
Are you pregnant?	☐	☐
Cancer	☐	☐
Circulation Problems	☐	☐
Any other illnesses or diagnoses?	☐ Yes	☐ No

Please indicate location of symptoms, here:



XXX	Sharp localized pain
////	burning
OOO	Numbness and tingling
→	Shooting pain

Please explain: _____

_____

Have you ever had surgery? If so, please describe: _____

_____

List any medications you are currently taking: _____

_____

Have you ever had Physical Therapy? ☐ Yes ☐ No

Date_____Location_____Condition_____

Date_____Location_____Condition_____

Date of injury/onset of symptoms: _____

What happened? _____

_____

Patient Name_____Date_____

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