

## **Outpatient Admission Consent & Agreement**

### **AUTHORIZATION FOR TREATMENT**

I hereby give my permission for authorized personnel of Back to Work Physical Therapy to perform all necessary procedures and treatments as prescribed by my physical therapist for the delivery of outpatient physical therapy services. I understand that I may refuse treatment or terminate services at any time and the agency may terminate their services to me at any time.

### **RELEASE OF INFORMATION**

I hereby authorize Back to Work Physical Therapy to release any medical records in its possession concerning my illness and/or treatment to my physician and my health insurance company. I also give permission to my physicians to release my medical information to Back to Work Physical Therapy. I hereby give permission for the review of my medical records by the accrediting agencies and/or other regulatory bodies. This authorization shall be valid for 6 months from the date this form is signed.

### **HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA)**

I acknowledge that I have been provided and have read a copy of my rights and responsibilities as a patient of Back to Work Physical Therapy according to the Health Insurance Portability and Accountability Act (HIPPA), and have been provided information on how to file a complaint should I desire to do so.

### **AUTHORIZATION FOR PAYMENT**

I authorize Back to Work Physical Therapy to bill for services rendered to me at this facility and to receive payment from my medical insurance carrier(s) for these services.

### **RELEASE OF LIABILITY**

I understand and expressly acknowledge that I release Back to Work Physical Therapy, the YMCA and its staff members from all liability for any injury, loss or damage connected in any way whatsoever to my participation in a physical therapy program. This release includes any claims based on negligence, action or inaction of Back to Work Physical Therapy and the YMCA, its staff, directors, members, and guests.

### **FINANCIAL RESPONSIBILITY**

I understand that if Back to Work Physical Therapy is not contracted as an "In-Network Provider" with my health insurance policy, payment may be forwarded directly to me. I agree to forward payment or will personally issue payments for these services to Back to Work Physical Therapy. I understand that denial of payment or reduction of rates by my health insurance company due to any of the following or any combination of the following: over-utilization, usual and customary, failure to pre-certify, contract limitations, non-covered services, exhaustion of benefits, etc., does NOT relieve my personal financial obligation for services rendered at Back to Work Physical Therapy. I agree to pay any outstanding sum I may have at this facility.

**PAYMENTS, SUCH AS DEDUCTIBLES, COPAYS, AND CO-INSURANCE PAYMENTS WILL BE EXPECTED AT EACH VISIT.**

**CANCELLATION POLICY**

I understand that if I need to reschedule or cancel my appointment at Back to Work Physical Therapy, I MUST do so at least 24 hours prior to the scheduled appointment. This policy is in effect out of consideration for the staff at Back to Work Physical Therapy, as well as other patients. **Please be advised that failure to cancel/reschedule an appointment 24 hours in advance will result in an automatic \$45 cancellation fee**, due at the beginning of your next appointment. By signing below, you are agreeing to abide by this cancellation policy and to take personal financial responsibility for the cancellation fee should you violate this agreement.

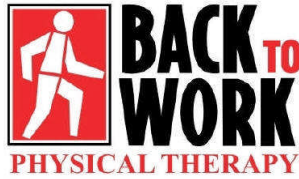
I have read and thoroughly understand/agree to all of the above and am voluntarily signing my consent to this authorization and release form.

\_\_\_\_\_  
Patient Name (PRINT)

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date

If Legal Guardian, Relationship to Patient: \_\_\_\_\_



## **Regarding Benefits & Eligibility**

Effective 1-1-08

As a courtesy to our patients, the staff at Back to Work Physical Therapy will verbally verify your physical therapy and/or massage therapy benefits/eligibility with your health insurance company prior to your first visit here. We will verbally inform you of the information we receive from your health insurance company. Please note that verbal verification of benefits is not a guarantee of payment: The WRITTEN terms of your health insurance policy are the basis for benefit decisions.

**WE STRONGLY ADVISE THAT YOU CONTACT YOUR HEALTH INSURANCE COMPANY TO VERIFY THIS INFORMATION YOURSELF.**

Back to Work Physical Therapy will not accept financial responsibility for misleading or incorrect information given to us by your health insurance company.

Also, it is your responsibility as a patient to keep track of the physical therapy limitations of your health insurance policy. Please note that limitations for physical therapy are often combined with, but not limited to; occupational therapy, speech therapy, cardiac rehabilitation, chiropractic services, and acupuncture services. You are financially responsible for any services rendered here after you have exceeded your therapy limitations.

Deductibles: Some health insurance policies subject physical therapy treatment to a deductible. If this applies to you, please note that deductibles reset to their full amount on a specific date each year, typically January 1<sup>st</sup>. You are financially responsible for any deductible on your policy. Health insurance coverage for physical therapy services will not be available until you have satisfied your deductible.

**By signing below, you are stating that you fully understand and acknowledge the above-mentioned information regarding eligibility and benefits, and that you agree to take full financial responsibility for all services rendered at Back to Work Physical Therapy.**

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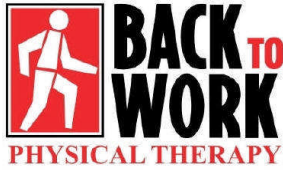
Patient Name (PRINT)

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Signature of Patient or Legal Guardian

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Date



## Patient Information Sheet

NAME \_\_\_\_\_ DATE \_\_\_\_\_  
(Last) (First) (Middle)

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_

STATE \_\_\_\_\_ ZIP \_\_\_\_\_

DATE OF BIRTH (Patient) \_\_\_\_/\_\_\_\_/\_\_\_\_ GENDER M F (Circle One)

NAME OF POLICYHOLDER (if different than Patient) \_\_\_\_\_  
(Last) (First) (Middle)

DATE OF BIRTH (Policyholder if different than Patient) \_\_\_\_/\_\_\_\_/\_\_\_\_

POLICYHOLDER GENDER M F (Circle One)

SOCIAL SECURITY # (if we are billing your workers comp insurance) \_\_\_\_/\_\_\_\_/\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

WORK PHONE (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

CELL PHONE (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ PPO POS HMO Work Comp Auto  
(Circle One)

INSURED'S ID NUMBER \_\_\_\_\_

INSURED'S GROUP/POLICY NUMBER \_\_\_\_\_

INSURED'S EMPLOYER \_\_\_\_\_

What is your Diagnosis / reason for coming to therapy? \_\_\_\_\_

\_\_\_\_\_

Who referred you to us? / How did you hear about us? \_\_\_\_\_

Full name of your primary care physician: \_\_\_\_\_

Full name of your referring physician: \_\_\_\_\_

Medical History

Have you had a physical exam in the past year? (circle) Yes / No

Please circle any of the physical problems listed below that you are currently experiencing or have experienced within the 5 years:

Allergies	Blood Clots	Numbness
Arthritis	Varicose Veins	Fractures
Cardiovascular/Heart Problems	Incontinence	Stroke
Respiratory/Lung Problems	Fatigue	Car Accident
Elevated Cholesterol	Cancer	Sciatica
High/Low Blood Pressure	Insomnia	Diabetes
Other: _____		

Have you had any surgery in the past 5 years? (circle) Yes / No  
If yes, please list: \_\_\_\_\_

Do you have a Pacemaker? (circle) Yes / No

Please circle if you have a family history of any of the following:

Heart Attack	Elevated Cholesterol
Heart Disease	High Blood Pressure
Stroke	Diabetes

Do you smoke? (circle) Yes / No If yes, Packs per day? \_\_\_\_\_

Do you exercise regularly? (circle) Yes / No If yes, how often? \_\_\_\_\_ / week

List all medications you are currently taking: \_\_\_\_\_  
\_\_\_\_\_

<b>FEMALES:</b> Do you believe you may be pregnant? (circle) Yes / No Are you currently taking hormones or hormonal contraceptives? (circle) Yes / No
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What is your chief complaint/condition that made you seek out physical therapy services?  
\_\_\_\_\_

What is the date of onset of the problem/complaint? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Have you see a physician specifically for this problem/complaint? (circle) Yes / No  
If yes, Whom?(full name please): \_\_\_\_\_  
Also, if yes; when is your follow-up appointment with this physician? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

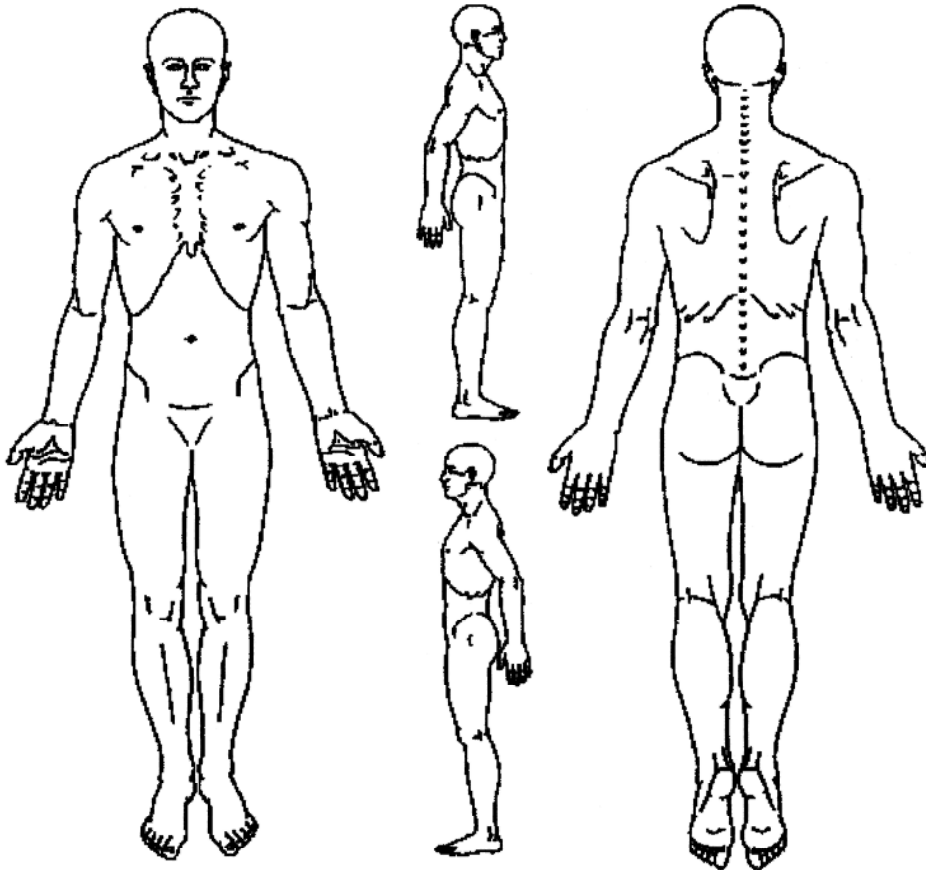
Have you ever been [or are currently being] treated for the same condition you are presently here for?  
(circle) Yes / No

Have you had surgery related to this problem/complaint? (circle) Yes / No

If yes, When? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

On the diagram below, please indicate with the letters below where you are experiencing any of the following:

**A** = Aching      **P** = Pins & Needles      **B** = Burning      **S** = Stabbing      **N** = Numbness      **T** = Tightness  
**O** = Other



Please indicate the intensity of these symptoms at this time: (circle)

Non-existent 0 1 2 3 4 5 6 7 8 9 10 Intolerable

What activities/treatments make your condition improve?

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What activities/treatments make your condition worsen?

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What are your expectations/goals for physical therapy treatment?

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Please list any other pertinent information that may be useful to the Physical Therapist:

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