ACIC PHYSICAL THERAPY

PATIENT INFORMATION

NAME (first, last):	DATE:	
STREET ADDRESS:	HOME PHONE:	
CITY:	STATE:	ZIP:
SSN: DRIVER'S LICENSE #:		EMAIL:
SEX: M ☐ F ☐	DATE OF BIRTH:	AGE:
DATE OF INJURY:	**CAUSE OF INJURY**:	**REFERRING MD:**
EMPLOYER NAME:	OCCUPATION:	
STREET ADDRESS:	WORK PHONE:	
CITY:	STATE:	ZIP:

PRIMARY INSURANCE		**SECONDARY INSURANCE**	
NAME OF INSURANCE:		NAME OF INSURANCE:	
MAILING ADDRESS:		MAILING ADDRESS:	
CITY:		CITY:	
STATE:	ZIP:	STATE:	ZIP:
PHONE:		PHONE:	
ID #:	GROUP #:	ID #:	GROUP #:

INSURED INFORMATION (RESPONSIBLE PARTY)

NAME:		NAME:	
SSN:		SSN:	
DATE OF BIRTH:		DATE OF BIRTH:	
STREET ADDRESS:		STREET ADDRESS:	
CITY:		CITY:	
STATE:	ZIP:	STATE:	ZIP:
EMPLOYER:		EMPLOYER:	
ADDRESS:		ADDRESS:	
RELATION TO PATIENT:		RELATION TO PATIENT:	

ATTORNEY INFORMATION – IF APPLICABLE

NAME: (first, last):	PHONE:	
STREET ADDRESS:	FAX:	
CITY:	STATE:	ZIP:

** We will update your Primary Care Physician as well as any additional Physicians requested that may be overseeing your health care.

PRIMARY CARE PHYSICIAN / ADDITIONAL PHYSICIANS

PHYSICIAN:	PHONE:	FAX:
PHYSICIAN:	PHONE:	FAX:
EMERGENCY CONTACT:	PHONE:	RELATION:

A.C.I.C. PHYSICAL THERAPY

Consent to Treatment & Therapeutic Procedures

I, _____ hereby consent to the therapeutic procedures outlined below to be performed by A.C.I.C. Physical Therapy and their associates

I agree to be evaluated and treated for functional loss due to related nerve, muscle and skeletal dysfunctions and/or pain. My results of the evaluation will be sent to my physician.

Updates in the form of a progress report will be done monthly, unless otherwise requested by the patient and/or physician, and sent to your physician.

I understand that treatment may include but are not limited to:

- Joint and soft tissue mobilization
- Clinic and home exercise programs including stretching, strengthening and balance/coordination exercises that you will be trained in.
- Functional retraining including posture and body mechanics
- Modalities such as heat, ice, electrical stimulation and ultrasound may be used to decrease pain/swelling.
- Special procedures such as taping and neuromuscular electrical stimulation
- Treatments will be delivered by a team of PT's, PT Assistants, PT Interns, and PT exercise specialists/aides.

I understand that I will be explained the purpose of the therapeutic procedures prior to receive treatment and that I may refuse any therapeutic procedure or treatment at any time.

I understand that I may consult with other therapists and/or physicians at any time regarding my condition.

I understand that no guarantees of a successful outcome have been given to me.

I understand that I can ask questions at any time regarding any aspect of my physical therapy care.

You should inform your physical therapist regarding any significant change in your symptoms, or activity e.g. before returning to sports, gym, etc.

Parents/guardians must attend all treatments unless otherwise agreed to, in writing. Minor patients will be supervised while in our offices, but not in public areas of the building complex.

I certify that I have read and understand the above consent statements:

Patient Name: _____

Patient's Signature: _____ Date: _____
Parent or Authorized Representative (if applicable)

A.C.I.C. PHYSICAL THERAPY

Financial Policy

INSURANCE BILLING
We will gladly call your insurance company to identify your current benefit coverage. However, please understand that insurance companies will not guarantee medical benefits over the phone. We can only use this information as an estimated guideline. Actual determination is made 2 to 8 weeks after we receive written notification and/or payments on your claim. We strongly encourage you to contact you insurance company directly in order to understand your plan's coverage and limitations

If charges billed to your insurance are not paid within 90 days the overdue amount will become the full responsibility of the patient and payment will be due at that time. (Note: most insurances pay within 2-4 weeks.) It will thin become the patient's responsibility to resolve the outstanding issue with their insurance company and receive their reimbursement from them.

It is the responsibility of our patients to provide us with the correct insurance information for billing to be done correctly and timely. It is also the responsibility of our patients to notify us if any of their insurance coverage information changes during the course of treatment.

Please be aware that most insurance companies have a timely filing policy. We must be given current information at the time of the change in order for your insurance to process them correctly. Your insurance will deny any claims if they are received after their timely filing period. You are fully responsible for the denied charges if the information is given to our office too late. Please contact your insurance if you are not sure of their time period for timely filing. Each insurances policy may vary.

Your insurance company may also require a current physical therapy prescription (prescriptions expire 30 days from the date they are written), a "Letter of Medical Necessity" written by your physician and/or preauthorization *directly from you physician* for therapy services. **This is your responsibility to obtain and noncompliance with this may result in services not being reimbursed by your insurance company.**

The patients agree to pay for all charges that are not covered by their insurance plans. This would include additional services and supplies requested by the patient.

PAYMENTS
All deductibles, co-pays, co-insurance and cash pay estimated amounts are due **at the time of service**, unless other written arrangements have been made with our Practice Manager.

Forms of payment: Cash, Check, Visa, MasterCard, American Express, and Discover Card

Returned checks:

a. A $25.00 service fee for the processing of returned checks will be applied to the patient responsibility side of your account.
b. Services may be discontinued until the returned check issues are fully resolved. If on-going treatment is required, the patient may be referred out to another provider.

PATIENT BILLING:
Once payment for services has been made by your insurance company, the patient portion of the charges will be transferred to your account and you will be expected to make payment at that time. Our billing system enables us to provide a very accurate estimate of the co-insurance that will be due on your account. We recommend that our patients pay as they go based on these estimates. The co-insurance payments are applied to your account as the 'Explanation of Benefits' arrive from your insurance company. If there is an underpayment of co-insurance, you will owe us the difference. If there is an overpayment of co-insurance we will refund that amount to you. Refunds are paid to the patients within 30 days of identifying the amount due. This policy has helped to reduce the balance due at the end of treatment for most patients.

Statements are mailed to patients monthly. **Payments are due upon receipt of your patient statements.**

If you do not make payment, we will make the three following attempts to resolve any conflicts that may exist.

1. Courtesy reminder notice
2. Second request to pay letter
3. Final 10-day demand letter

Unresolved financial disputes for non-payment of fees for services rendered will result in discontinuation of services, referral to another provider as necessary, and assignment of collection responsibility for this account to a professional Collection Agency.

A.C.I.C. reserves the right to charge interest at the legal prevailing rate (up to a maximum of 10% per annum) and to apply late payments or service fees for multiple payment plans as necessary to manage the collection of your account.

By signing this form, I the patient (or legal guarding of the patient), have read, understood and agree that I am 100% responsible for all fees incurred here at A.C.I.C. PHYSICAL THERAPY.

I agree to authorize A.C.I.C. PHYSICAL THERAPY to release my medical information to my insurance company, physician(s), attorney(s), and to all other pertinent parties that may be involved in my claim or care.
I hereby authorize payment be made directly to A.C.I.C. PHYSICAL THERAPY of the benefits otherwise payable to me for services rendered.

I agree that if it should become necessary to forward my account to a collection agency, I will be responsible for the fee charged by the collection agency for the costs of collection.

_____
Patient Name (please print)

_____ _____
Patient Signature Date

_____ _____
Signature of Representative / Legal Guardian Relationship to Patient

To Medicare Beneficiaries:

As of January 1, 2011, Medicare has placed a limit on the amount they will pay for outpatient physical therapy and speech therapy services.

The 2013 annual capitated allowed amount per beneficiary is $1900. Medicare will pay 80% of the allowed amount, which will be $1520. After your $147 annual deductible has been met. This limit is for both physical therapy and speech therapy services combined.

A.C.I.C. Physical Therapy will not compromise your care in any manner. We will assist you in tracking your visits and limits. You should however, check your Medicare Summary Notices for how much of the capitation you have used. If you reach your limit and need to continue physical therapy, we will work with you on a self-pay basis to continue your care so that your functional outcome will be maximized. Upon reaching your allowable limit, you will also have the option of receiving covered services in a hospital outpatient therapy setting.

To assist us in tracking your available benefits, please answer the following questions:

Have you received any physical therapy since 1/1/2013? ☐ **Yes** ☐ **No**
If yes, check the location in which the treatment was received.

☐Hospital ☐Home Health ☐Outpatient Clinic ☐Rehab Facility ☐Doctor's Office

If you are unsure, please feel free to ask a staff member for assistance.

Supplies:

Medicare also does not reimburse for certain clinical supplied used in physical therapy such as Iontophoresis pads and tape. Although these supplies are less commonly used, if you therapist or physician feels these items are necessary, we will explain the purpose and cost of each item before the procedure is done. You will have the option of paying for and receiving the supplies or not receiving/using the supplies.

If you have any addition questions regarding your Medicare benefits, please feel free to ask our Front Desk Receptionist or contact you Medicare carrier at the number listed on the front of your Medicare Summary Notice or call toll free at: 1-800-MEDICARE (633-4227).

I have read and understand the above information regarding the Medicare rehabilitation services capitation and reimbursement regarding clinical supplies.

_____ _____
Patient Signature Date

_____ _____

Witness Signature Date

A.C.I.C. PHYSICAL THERAPY

Patient Commitment & Missed Appointment Policy

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well-being and gain of your physical abilities is something every one in our clinic takes quite seriously.

Because we care so much about you we realize it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore, we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep all your appointments. Write down the time of your visits.

If you need to re-schedule an appointment we require 24 hours notice. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferable the very next day.

In an instance of cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a $35 fee. The only exception to the cancellation fee is in the case of an emergency

If repeated non-compliance (cancellations and/or no-shows) with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We greatly appreciate you as our patient and strive to accomplish wonderful results and success for you.

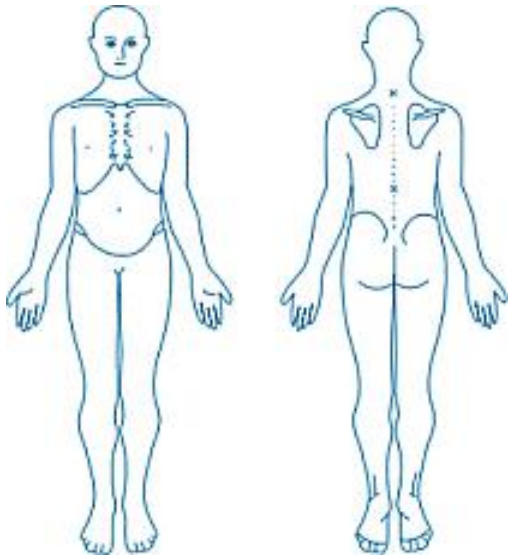
I certify that I have read, understand and agree to adhere to the above policy:

_____
Patient Name (please print)

_____ _____
Patient Signature Date

_____ _____
Signature of Representative / Legal Guardian Relationship to Patient

Please indicate on the body chart below, the location of your injury or condition. Also indicate the quality of your injury, condition, or pain (i.e., ache, sharp, dull, weakness, shooting, etc.)



On a scale from 0 to 10, please indicate the range of your discomfort/pain (best to worst):

0 1 2 3 4 5 6 7 8 9 10

NO PAIN UNBEARABLE

Symptoms are aggravated by: _____

Symptoms are eased by: _____

Symptoms are better in the: am_____ pm_____

Please check those activities that you are unable to perform since your injury / surgery and would like to resume.

Walking [ ]
Running [ ]
Going up / down stairs [ ]
Bending [ ]
Lifting [ ]
Sitting [ ]
Standing [ ]
Throwing [ ]
Reaching overhead [ ]
Other: _____

Activities of Daily Living:
Dressing [ ]
Grooming [ ]
Eating [ ]
Cleaning [ ]
Driving [ ]

Sports Activities: _____

MEDICAL HISTORY AND PHYSICAL CONDITION

NAME: _____ DATE: _____

CHIEF COMPLAINT: _____

1. Do you now have or have you in the past, had any of the following conditions:

Allergies	yes ☐	no ☐	Hernia	yes ☐	no ☐
Balance Problems	yes ☐	no ☐	High Blood Pressure	yes ☐	no ☐
Circulatory Problems	yes ☐	no ☐	HIV / AIDS	yes ☐	no ☐
Diabetes	yes ☐	no ☐	Kidney Problems	yes ☐	no ☐
Dizzy Spells	yes ☐	no ☐	Nervous Disorder	yes ☐	no ☐
Headaches	yes ☐	no ☐	Pregnancy	yes ☐	no ☐
Hearing Problems	yes ☐	no ☐	Seizures	yes ☐	no ☐
Heart Attack	yes ☐	no ☐	Sensitive to heat / cold	yes ☐	no ☐
Heart Disease	yes ☐	no ☐	Vision Problems	yes ☐	no ☐

If yes on any of the above, please explain and give approximate dates of occurrences:

_____

_____

2. Have you had treatment for this / these problems before? Yes ☐ No ☐

If yes, where and when were you treated? _____

3. Have you had surgery related to this / these problems? Yes ☐ No ☐

If yes, what type of surgery did you have and when was the surgery? _____

4. Do you currently have any metal implants? Yes ☐ No ☐

5. Do you currently have a pacemaker? Yes ☐ No ☐

6. Do you have any communicable diseases? Yes ☐ No ☐

7. List any medications you are currently taking:

_____ _____

_____ _____

_____ _____

A.C.I.C. Physical Therapy

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____

Medical Record #: _____

I hereby acknowledge that I have received a copy of A.C.I.C. Physical Therapy's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____ _____
Patient Signature Date

_____ _____
Representative Signature (if applicable) Relationship to Patient

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FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date, _____ but acknowledgement could not be obtained for the following reason(s):

_____ Patient / Patient Representative refused to sign

_____ Emergency situation prevented us from obtaining acknowledgement at this time, will attempt at a later date

_____ Communication barriers prohibit obtaining acknowledgement. (explain):
_____
_____

_____ Other (specify)
_____
_____

ACIC Representative: _____