ACIC PHYSICAL THERAPY

PATIENT INFORMATION

NAME:	CELL PHONE:	DATE:
STREET ADDRESS:	HOME PHONE:	
CITY:	STATE:	ZIP:
SSN: DRIVER'S LICENSE #:		EMAIL:
SEX: M ☐ F ☐	DATE OF BIRTH:	AGE:
ONSET DATE:	**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:
EMP ADDRESS CITY & PHONE:	EMP CITY & PHONE:
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:**

FINANCIAL LIABILITY AGREEMENT

_____ I understand that all co-payments, co-insurances, deductibles and cash payments are due at the time of service, unless other written arrangements have been made with our Practice Manager.

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

Returned checks: A $25.00 service fee for the processing of returned checks will be applied to patient responsibility.

_____ I understand that if my insurance does not issue payment within 90 days of that date of service, I will be financially responsible for the entire balance. I may pursue my insurance carrier at the time to render payment and once settled if due, I will receive a refund for any overpayment.

_____ I understand that it is my responsibility to inform this office of any changes in my insurance coverage during my course of treatment. I am aware that there is a timely filing policy with my insurance and the office may not be able to re-bill if current insurance information is not furnished in a timely manner.

_____ I understand that this office will verify that benefits at the time of service but I am responsible for knowing my benefits and will be responsible for contacting my insurance carrier for details. You may request a copy from our office but understand that it is not a guarantee of coverage.

_____ I understand that my insurance company may also require a current physical therapy prescription, a "Letter of Medical Necessity" written by your physician and/or preauthorization *directly from your physician* for therapy services. **This is your responsibility to obtain and that noncompliance with this may result in services not being reimbursed by your insurance company.**

_____ I understand that I will be financially responsible for all services or supplies that are NOT covered by my insurance. This includes Durable Medical Equipment such as taping.
Unresolved financial disputes for non-payment of fees for services rendered will result in discontinuation of services and assignment of collection responsibility for this account to a professional Collection Agency.

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

_____ I understand 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.
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 for the benefits otherwise payable to me for services rendered.

By signing this form, I the patient (or legal guarding of the patient), have read, understood and agree with the terms of this financial liability agreement.

_____ _____ _____
Patient Name (please print) Patient Signature (or Legal Guardian) 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 (or Legal Guardian) Date

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: _____

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.

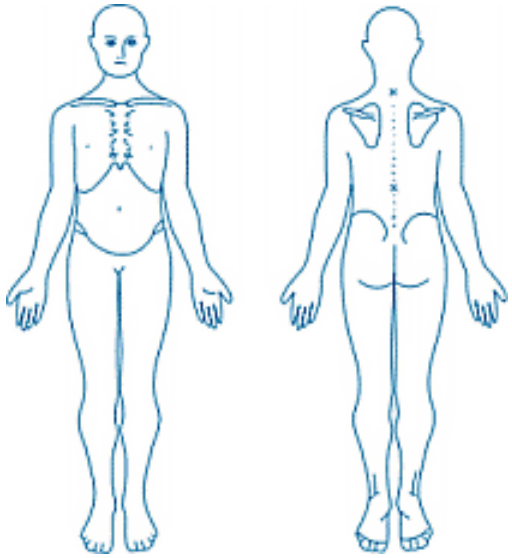
Parents/guardians must attend all treatments unless otherwise agreed to, in writing. Minor patients will be supervised while in our offices, but not in public areas of the building complex.

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

Patient Name:_____

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

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	[ ]	Activities of Daily Living:	[ ]
Running	[ ]	Dressing	[ ]
Going up / down stairs	[ ]	Grooming	[ ]
Bending	[ ]	Eating	[ ]
Lifting	[ ]	Cleaning	[ ]
Sitting	[ ]	Driving	[ ]
Standing	[ ]		
Throwing	[ ]		
Reaching overhead	[ ]		

Other: _____ Sports Activities: _____

Patient Name: _____ Date: _____

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:

_____ _____

_____ _____

_____ _____