ENVISION PHYSICAL THERAPY MED INSURANCE/WORK COMP/SELF-PAY

Name: _____ Today's Date: _____

Date of Birth: _____ Contact Phone: _____

Address: _____ Email: _____

_____ Emergency Contact: _____

City/State/Zip: _____ Emergency Phone: _____

How did you hear about us? _____

Do you have a referral for physical therapy? □ No or N/A □ Yes; (by whom?): _____

Have you had any treatment for this injury? □ No □ Yes _____

Date of injury or onset of symptoms: _____

Briefly describe your symptoms/reason for your visit: _____

_____

Medical History (please check all that apply):

□ Allergy to Latex, Food, or Medication (specify):
□ Angina/Chest Pain
□ Anxiety and/or Depression
□ Arthritis
□ Asthma or Breathing Difficulties
□ Blood Pressure (specify): High Low
□ Cancer
□ Circulatory Disorder or Peripheral Vascular Disease
□ Defibrillator or Pacemaker
□ Diabetes
□ Fibromyalgia
□ Headaches or Migraines
□ Heart Arrhythmia
□ Heart Disease and/or Heart Attack
□ Hepatitis
□ Hernia(s) or Hernia Repair
□ HIV
□ Joint Replacement and/or Metal Implants
□ Multiple Sclerosis
□ Neuropathy
□ Osteopenia or Osteoporosis
□ Pregnant and/or Breastfeeding (currently)
□ Parkinson 's Disease
□ Scoliosis
□ Seizure(s)
□ Smoker (current)
□ Stroke or TIA
□ Spinal Disk Herniation
□ Spinal Fusion
□ Thyroid Disorder

Please list any hospitalizations and/or surgical procedures: _____

_____

Please list any current medications and/or nutritional supplements: _____

_____

I acknowledge that the health history information provided above is accurate to the best of my knowledge.

Signature: _____ Date: _____

ENVISION PHYSICAL THERAPY

FEE SCHEDULE, PAYMENT AND POLICIES, ASSIGNMENT OF BENEFITS, AND RELEASE OF RECORDS

FEE SCHEDULE:

Physical Therapy Evaluation Low Complexity (97161)	Unit Rate: $250
Physical Therapy Evaluation Med Complexity (97162)	Unit Rate: $250
Physical Therapy Evaluation High Complexity (97163)	Unit Rate: $250
Therapeutic Exercise (97110) 15-minute treatment	Unit Rate: $70
Manual Therapy (97140) 15-minute treatment	Unit Rate: $70
Massage or Corrective Exercise/Wellness 30-minute treatment	Unit Rate: $45

PLEASE REVIEW EACH STATEMENT AND INITIAL TO ACKNOWLEDGE:

CONSENT TO TREATMENT AND RESPONSIBILITY TO NOTIFY PROVIDER OF CHANGES IN CONDITION:
I understand participation in a physical, massage or exercise therapy program carries with it a risk that certain physiological responses may occur. These may include but are not limited to changes in blood pressure, fainting, irregular heartbeat or heart attack. It is my responsibility to communicate to my provider any injury or change in physical condition, including hospitalization or medical procedures, which may affect my ability to participate **prior** to beginning each treatment session. **Initials:** _____

CANCELLATION POLICY: Failure to cancel your scheduled appointment within 24 hours of the appointment time will result in a $35 cancellation fee. If applicable, your insurance company will not be charged for your missed appointment, you will be responsible for payment out of pocket. **Initials:** _____

RIGHT OF REFUSAL: We reserve the right to refuse service to anyone, including any request for treatment outside our scope of practice as well as to anyone under the influence of drugs or alcohol. We also reserve the right to charge for the session time, if above status applies. **Initials:** _____

ASSIGNMENT OF BENEFITS: I hereby direct my insurance company: _____ and instruct you to make payment directly to Envision Physical Therapy for medical claims submitted by them on my behalf for medically necessary treatment. Your denial or delay to do so in a timely manner will be considered just cause for myself or provider to file a complaint with the insurance commissioner. I hereby give my permission to the Envision Physical Therapy to file this complaint on my behalf if deemed necessary. **Initials:** _____

RELEASE OF RECORDS: I hereby authorize Envision Physical Therapy to release to any attorney, physician, or insurance company, involved in my case, any medical records or other information necessary to process my claim, which will be utilized for the ultimate recovery of benefits related to my injury/illness. **Initials:** _____

I understand the fee schedule for services provided by Envision Physical Therapy. I have read the facility policies, assignment of benefits, and release of records stated above and agree to abide by them.

Print Name: _____

Signature: _____ **Date:** _____

ENVISION PHYSICAL THERAPY

OTHERS INVOLVED IN MY HEALTHCARE

Patient Name: _____ Date of Birth: _____

Employees and its providers of Envision Physical Therapy **MAY DISCUSS** all aspects of my healthcare with:

Print Name: _____ Relationship: _____

Print Name: _____ Relationship: _____

Print Name: _____ Relationship: _____

Print Name: _____ Relationship: _____

As the patient, you may also request that any part of your private health information (PHI) not be discussed with others involved in your care or for notification purposes, this includes family members or friends, as described in the notice of privacy practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician does agree to the restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

Envision Physical Therapy providers or employees **MAY NOT DISCUSS** aspects of my healthcare with:

Print Name: _____ Relationship: _____

Specific restriction: _____

Print Name: _____ Relationship: _____

Specific restriction: _____

Print Name: _____ Relationship: _____

Specific restriction: _____

ENVISION PHYSICAL THERAPY

RECEIPT OF PRIVACY NOTICE

My signature, below, certifies I have received or reviewed a copy of the NOTICE OF PRIVACY PRACTICES.

Patient's Printed Name: _____

Signature: _____

Patient Date of Birth: _____ Today's Date: _____

Comments: _____

_____

ENVISION PHYSICAL THERAPY

Below are the telephone numbers that must be posted by each licensed FQA facility to comply with CORE 408.801(5)(a)1. And 2. See statute below.

The complaint number is our agency toll free # 1-888-419-4356

The abuse line is 1-800-96-ABUSE (962-2873)

CaraLee Starnes, Long term care

408.810(5)(a) On or before the first day services are provided to a client, a licensee must inform the client and his or her immediate family or representative, if appropriate, of the right to report:

1. Complaints. The statewide toll-free telephone number for reporting complaints to the agency must be provided to clients in a manner that is clearly legible and must include the words: "to report a complaint regarding the services you receive, please call toll free 1-888-4119-3456"

2. Abusive, neglectful, or exploitative practices. The statewide toll free telephone number for central abuse hotline must be provided to clients in a manner that is clearly legible and must include the words: "to report abuse, neglect or exploitation, please call toll free 1-888-96-ABUSE (962-2873)." The agency shall publish a minimum.