

Allied Physical Therapy, PA

Dear Patient,

We are pleased that you have chosen Allied Physical Therapy for your physical therapy needs.

Please take time to fill these forms out completely **prior** to your scheduled appointment so that the therapist can spend the full appointment with you.

On the day of your appointment, please bring:

- Completed forms
- Insurance card(s)
- Prescription for physical therapy with diagnosis

PLEASE NOTE: If you have an insurance plan that requires a referral/authorization to see a specialist, Please contact your primary care physician or medical group to obtain a referral prior to your appointment date.

Please arrive 15-30 minutes early to allow sufficient time for check-in.

Sincerely,

Allied Physical Therapy, PA

Please tell us how you found us:
(Please check all that apply)

- My doctor referred me to your clinic**
 - I found out about your clinic from a friend**
 - I was a previous patient**
 - Family member**
 - I heard about your services from one of your physical therapists**
 - I learned of your clinic from my Insurance Company**
 - I learned of your clinic and services from the internet**
 - Other**
-

ALLIED PHYSICAL THERAPY, PA

PATIENT INFORMATION

**** Please present your insurance card(s) for copying. ****

First Name:		MI:	Last:
Address:			
City:		State:	Zip:
BirthDate:	Age:	Email Address:	
Sex: M F	Referring M.D		
Social Security:	Primary Care M.D		
Home Phone:	Ok to leave message? Yes No	Employment: Full Part Retired Unemp Student	
Work/Cell Phone:	Ok to leave message? Yes No	Marital Status: Single Married Divorced Other	
Emergency Contact:			Relationship:
Home Phone:		Work/Cell Phone:	

CANCELLATION POLICY and CONSENT TO TREAT

*We at Allied Physical Therapy want to provide the best possible care for our patients and attending your scheduled appointments is a necessary part of the treatment process. **If there is not notice of cancellation 24 hours before the scheduled appointment, a \$25 cancellation charge will be billed directly to the patient for each cancellation.***

By signing below, you acknowledge that you have read, understood and agree to abide by our cancellation policy as described. You also acknowledge the above patient information is correct to the best of your knowledge.

I grant permission for the staff of Allied Physical Therapy, PA to perform the procedures as prescribed by my physician including a physical therapy evaluation. During this evaluation, the nature of the procedures that will be performed as well as the potential risks of care will be explained to me.

If I become ill while undergoing treatment, I give permission to the staff to administer treatments which they consider necessary to my well-being. My signature below indicates that I understand and give consent to be treated as explained above.

Patient Signature:	Guardian's Signature: (If patient is <18 years old)	Date:

1413 Viscaya Pkwy
Cape Coral, FL 33990
Tel: 239-242-0070
Fax: 239-242-0076

Medical History Historial Medico

Patient Name:	Referring Doctor:
Nombre del Paciente:	Referido por Doctor:

Musculoskeletal (Músculo Esquelético)

- Muscle/Joint Pain (Dolor en Músculo/Coyunturas)
- Back Pain (Dolor de Espalda)
- Arthritis (Artritis)
- Osteoporosis (Osteoporosis)
- Fracture (Fracturas)
- Joint Replacement (Reemplazo de Coyunturas)

Nuerological (Neurológico)

- Headaches (Dolor de Cabeza)
- Memory Loss (Pérdida de Memoria)
- Fainting (Desmayos)
- Stroke (Ataque)
- Back Problems (Problemas de Espalda)

Gastrointestinal (Gastrointestinal)

- Blood or Change in Bowel Movement
(Sangre o Cambios en la Evacuación)
- Nausea/Vomiting (Náusea/Vomito)
- Constipation/Diarrhea (Estreñimiento/Diarrea)

Pain (Dolor)

- Location (Localizacion) _____
- Type (Tipo) _____

Cardiovascular (Cardio Vascular)

- Fever/Sweats (Fiebre/Sudores)
- Short of Breath (Corto de Respiración)
- Palpitations (Palpitaciones)
- High Blood Pressure (Hipertensión)
- High Cholestrol (Colesterol Alto)
- Chest Pain/Discomfort (Dolor de Pecho/Molestia)
- Heart Disease (Enfermedad del Corazón)
- Pacemaker (Marca Pasos)

Psychiatric (Siquiátrica)

- Anxiety (Ansiedad)
- Depression (Depresión)
- Sleep Disturbance (Sueño Disturbios)

Urinarie (Urinario)

- Painful/Bloody Urination (Dolor o Sangre al Orinar)
- Leaking Urine (Incontinencia de orina)
- Concerns with Sexual Functions
(Preocupaciones con Funciones Sexuales)
- Pelvic Pain (Dolor Pélvico)

Medications Medicamentos

Please list all medications

Favor listé todos los medicamentos

1	6
2	7
3	8
4	9
5	10

Please list surgery type and date:

Favor de listar tipo de cirugía y fecha

Patient Signature : _____

Date: _____

Firma del Paciente: _____

Fecha: _____



Consent to Treat

I do hereby consent to such treatment by the authorized licensed personnel of Allied Physical Therapy as may be dictated by prudent medical practice by my illness, injury or condition.

Thank you for allowing us the opportunity to serve you. If you have any questions about the above information or any uncertainty regarding your insurance coverage, please ask for assistance. Kindly sign and date this form to indicate that you understand and agree to the terms of this payment/consent to treat.

Please be advised that we are not a credit guarantor. Therefore, failure to maintain these arrangements may result in the placement of your account with an outside collection agency or attorney for collections. You will remain financially responsible for services rendered, regardless of the payment option selected above. In the event your account becomes delinquent and is therefore default of payment, the patient, legal guardian, or admitting parent will be responsible for the principle amount owed and all reasonable costs associated with the recovery of this debt.

Sign Name

Date

Consentimiento para Tratamiento

Yo por la presente doy consentimiento a tratamiento por el personal licenciado autorizado de Allied Physical Therapy puede ser dictado como por consultorio médico prudente por mi enfermedad, herida o condición.

Gracias por permitirnos la oportunidad de servirle. Si usted tiene cualquier pregunta acerca del su cubierta de seguro medico favor de pedir ayuda. Favor de firmar y fechar esta formamulario para indicar que usted comprende y acepta los términos de esta política de pago/consentimiento para ser tratado.

Por favor este advertido que nosotros no somos un garantizador de crédito. Por lo tanto, sino mantenie estos arreglos su cuenta puede ser colocada con una agencia de colección exterior o abogado para colecciones. Usted permanecerá económicamente responsable de servicios dados, sin tener en cuenta la opción de pago seleccionada encima. En el evento que su cuenta se hace delincuente por falta de pago, el paciente, guardián legal, o padre de admisión será responsable de la cantidad del principal debido y todos los gastos razonables asociados con la recuperación de esta deuda.

Firmar Nombre

Fecha

**ALLIED PHYSICAL THERAPY, PA
Office Payment Policy**

It is the policy of Allied Physical Therapy Corp. that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their deductible, co-pay and/or co-insurance payment at the beginning of each visit. At the conclusion of your therapy with Allied P.T, you may be billed for any outstanding balances. If there is a positive balance or credit, you will be provided a refund promptly.

If you are covered by health insurance with physical therapy benefits, we will be happy to bill your insurance. Please provide your insurance information to the office staff and we will verify your coverage as a courtesy. Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by a physician does not necessarily guarantee that your insurance will cover our services. **Please remember that you are 100% responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.** Therefore, we highly recommend you also contact your insurance carrier and check into your coverage for physical therapy. Do not assume that you will not owe anything if you have more than one insurance policy. If you need special arrangements to be made, please discuss this with the business manager before starting your treatments.

Please initial your payment method and sign below that you have read, understand, and agree with all of the information on this page:

- _____ 1. **PRIVATE HEALTH INSURANCE (PPO):** Some insurance plans require authorization or a referral from your primary physician. Most insurance plans have a patient responsibility (deductible or amount paid by the patient before the insurance policy begins payment for services) and/or a co-pay (set dollar amount per visit) or coinsurance (a percent of the allowed charges). **Deductibles, copay, and coinsurances, are due at the time of service.** Should your insurance deny coverage, we will bill you for the outstanding amount.

- _____ 2. **HMO Insurance:** Authorization from your insurance must be obtained prior to treatment. Any copay or coinsurance is due at the time of treatment. If your HMO plan also has a Point of Service option you are using, please be sure you understand the difference in your Point of Service coverage verses your HMO coverage.

- _____ 3. **MEDICARE:** Allied Physical Therapy, PA is a certified Medicare provider. Some secondary insurance plans cover the portion due and services after Medicare benefits are exhausted, but not always. All Medicare covered patients are subject to an annual deductible and a cap to physical therapy benefits.

- _____ 4. Secondary Medicare Insurance Provider: _____

- _____ 5. **NO INSURANCE (CASH):** If you do not have insurance you may be eligible for an administrative discount if payment is received at time of service. Please notify the office staff that you do not have insurance so that a payment plan can be discussed.

- _____ 6. **WORKER'S COMPENSATION CLAIMS:** Authorization from your insurance adjuster is required before you can begin treatment. Please provide the office with the name and phone number of your adjuster, the date of your injury and your claim number, and any other pertinent information.

****I have reviewed this office payment policy and discussed it with the office. All my questions have been answered to my satisfaction and I understand all the information that has been explained to me:**

Patient Signature:	Guardian's Signature: (If patient is <18 years old)	Date:

Payment Policy

Welcome to Allied Physical Therapy! We are happy to further extend your services by filing your primary and/or secondary insurance for you. Please be sure to read all of the following information carefully:

- According to _____ (insurance carrier) you have satisfied \$_____ of your \$_____ (yearly) deductible. The balance of \$_____ is payable at the time of service (as based upon your insurance's fee schedule).
- A co-payment of \$_____ or _____% is due at each visit.
- Worker's Compensation: We will bill your worker's compensation carrier for all charges.
- Self-Pay: Balance is due in full at the time services are rendered.
- Motor Vehicle you are responsible for _____%

Cancellation Policy

It is our policy to charge a \$25 fee for Cancellation or No Show to your appointment. If for any reason you cannot keep your appointment, please call 24 hours prior to your appointment to cancel. This is not covered by your insurance and you will be responsible.

Please Note: It is our policy that the patient will be discharged from our services after three cancellations or no-shows for his/her appointments.

Sign Name

Date

Poliza de Pago

¡Bienvenido a Allied Physical Therapy! Estamos felices de poder extender aún más sus servicios facturando les a su seguro primario y/o secundario para usted. Favor de leer toda la información siguiente con cuidado:

- De Acuerdo a _____ (su seguro) usted ha satisfecho \$_____ de su \$_____ deducible anual. El balance de \$_____ es pagable en el momento que recibe el servicio, y es basado en los honorario de su seguro.
- Un co-pago de \$_____ o _____% es pagable en cada visita.
- Compensación de Trabajo: Facturaremos a su seguro de compensación por todos los cargos.
- Pago por Cuenta Propia: El balance sera pagado en su totalidad en el momento que los servicios sean rendidos.

Poliza de Cancelacion

Es nuestra poliza de cargar un honorario de \$25 por la Cancelación o no asiste a su cita . Si por alguna razón usted no puede acudir a su cita, favor de llamar con 24 horas antes de su cita para cancelar. Esto no es cubierto por su seguro y usted será responsable.

Favor de notar: Es nuestra política que el paciente sea dado de baja de nuestros servicios después de tres cancelaciones o ausencias a sus citas.

Firma

Fecha

ALLIED PHYSICAL THERAPY, PA

ACKNOWLEDGEMENT OF PATIENT INFORMATION PRACTICES

I have read and fully understand Allied Physical Therapy's Notice of Patient Information Practices. I understand that Allied Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Allied Physical Therapy's Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name:

Signature (Guardian if patient is a minor)

Date:

ALLIED PHYSICAL THERAPY, PA

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

ALLIED PHYSICAL THERAPY, PA LEGAL DUTY

Allied Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Allied Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Allied Physical Therapy may also use or disclose your personal health information without prior authorization for emergencies, research studies, auditing purposes, and public health/statistical purposes. We also provide information when required by law. In any other situation, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Allied Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances.

CONCERNS AND COMPLAINTS

If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Privacy Officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on our health information practices or if you have a complaint, please contact the following person:

ALLIED PHYSICAL THERAPY, PA

Attn: Zaida Marrero, Privacy Officer

1413 Viscaya Pkwy, Cape Coral, FL 33990 Tel: (239)242-0070****Fax: (239) 242-0070