



Please carefully review our financial policies to answer any questions you may have regarding your services with us.

- All co-pays are due at the time of service.
- We accept cash, checks, Visa and Mastercard.
- Payment in full may be due at the time of service depending upon services rendered.

Financial Policy

Deductible \$ _____ / \$ _____ met

Co-pay/coinsurance _____

Out of pocket \$ _____ / \$ _____ met

Date Verified: _____

☐ N/A - no patient responsibility

Insurance: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you we will bill your insurance provider for the services rendered. Your contract dictates the services that are covered and the amount of payment for those services. You are responsible for payment of services provided, a physician's referral and our verification of insurance does not guarantee payment. Please advise our clinic of any changes or updates in address, insurance, phone, new injury or employment changes to ensure accurate billing.

Medicare Patients: As of January 1, 2006 Medicare has a dollar amount cap for outpatient Physical Therapy benefits. Your supplemental plan may provide coverage beyond this cap. It is your responsibility to be aware of the remaining benefits under Medicare. This waiver is an acknowledgement that you are aware of the Medicare cap and that you are responsible for paying the balance on any visits that Medicare or your insurance does not.

Workers Compensation Claims/Self-Insured Claims: Please provide the office the name and phone number of your claims representative before you begin treatment. We request your private insurance information at the time of service. If your L&I claim is not accepted we will bill your private insurance. You are responsible for payment of services rendered if your claim is not accepted.

Motor Vehicle Collisions: We will bill your Personal Injury Protection Insurance (PIP) as a courtesy to you. However, you are fully responsible for the bill. In the event that payment has not been made within 30 days, you will be required to make payment arrangements.

Private Pay/No Insurance: Full payment is due at the time of service.

Doctor Referrals: You are responsible for obtaining a referral and/or prescriptions from your primary care physician prior to your appointment. It is your responsibility to make sure we have a valid and current copy of your referral/prescription in the office at the time of your appointment. Exceptions to this policy are plans that have direct access to therapy with no referral required.

Payment Issues: Please contact our Billing department as soon as possible if financial problems arise. If an account becomes past due, necessary action will be taken, up to and including collections or legal action. The undersigned understands that he/she or his/her agent is responsible for charges incurred.

Cancellations and No Show appointments: If you are unable to make your scheduled appointment we ask that you contact our office to cancel your appointment. If appointments are cancelled with less than 48 hour notice there is a \$45 cancellation fee that will be the patient's responsibility.

Initial

I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that the benefits quoted to me are not a guarantee of claim payment. I understand that payment is dependent on my eligibility at the time of service and ALL terms and conditions of my insurance plan. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges.

Initial

I authorize Capstone Physical Therapy to release any necessary information requested by my insurance carrier and authorize payment directly to Capstone Physical Therapy for any benefits available under my insurance plan. I have read and understand the above mentioned and consent to evaluation and treatment. I have carefully read the Financial Policy and agree to the terms therein.

Signature of Patient or Responsible Party

Print Name

Date

Please fill out the following questionnaire as completely as possible. This enables your therapist to design a safe and appropriate treatment plan for you. Your input is very important.

Case History

Primary Reason for Visit: _____ Condition Began: ____/____/____

Secondary Reason for Visit (if applicable): _____ Condition Began: ____/____/____

Is this a work related injury? ☐ Yes ☐ No Date of Next Doctor's Appt for this Condition: ____/____/____

Describe the Onset and History of Current Conditions: _____

Rate Symptom Intensity in the Past 5 Days (0 is no pain or symptoms and 10 is the worst possible pain or symptoms - circle one)

Symptoms at Worst: 0 1 2 3 4 5 6 7 8 9 10

Symptoms at Best: 0 1 2 3 4 5 6 7 8 9 10

Have you Received Therapy in the Past 12 Months? ☐ Yes ☐ No If yes, for what condition? _____

Medical History

Do you have a history of:

Height: ____' ____"

Weight: ____ lbs

- | | | | |
|---|--|---|--|
| ☐ Abnormal Bleeding | ☐ COPD | ☐ Gout | ☐ Multiple Sclerosis |
| ☐ Angina | ☐ Crohn's Disease | ☐ Heart Disease | ☐ Myocardial Infarction |
| ☐ Anxiety | ☐ Currently Pregnant | ☐ Hepatitis B | ☐ Osteoarthritis |
| ☐ Arrhythmia | If yes, wks _____ | ☐ Hepatitis C | ☐ Osteoporosis |
| ☐ Asthma | ☐ CVA (Stroke) | ☐ Hiatal Hernia | ☐ Pacemaker |
| ☐ Bipolar Disorder | ☐ Degenerative Disc Disease | ☐ High Cholesterol | ☐ Psoriatic Arthritis |
| ☐ Blood Clotting Disorder | ☐ Dementia | ☐ HIV/AIDS | ☐ PTSD |
| ☐ Bowel Incontinence | ☐ Depression | ☐ Hypertension | ☐ PVD |
| ☐ Cancer | ☐ Diabetes Type I | ☐ Hyperthyroidism | ☐ Rheumatoid Arthritis |
| ☐ Carpal Tunnel Syndrome | ☐ Diabetes Type II | ☐ Hypothyroidism | ☐ Scoliosis |
| ☐ Cellulitis | ☐ Dizziness | ☐ Irritable Bowel Syndrome | ☐ Seizure Disorder |
| ☐ Chronic Back Pain | ☐ DVT | ☐ Joint Pain | ☐ Shortness of Breath |
| ☐ Chronic Neck Pain | ☐ Fibromyalgia | ☐ Low Blood Pressure | ☐ Sleeping Disorder |
| ☐ Closed Head Injury | ☐ Frequent UTI | ☐ Lymphedema | ☐ TB |
| ☐ Colitis | ☐ GERD | ☐ Migraine/Headaches | ☐ Urinary Incontinence |
| ☐ Congestive Heart Failure | ☐ Glaucoma | ☐ MRSA | ☐ Vertigo |

Other Conditions Not Listed Above: _____

Primary Care Physician: _____ Referring Doctor (if different): _____

Surgical History

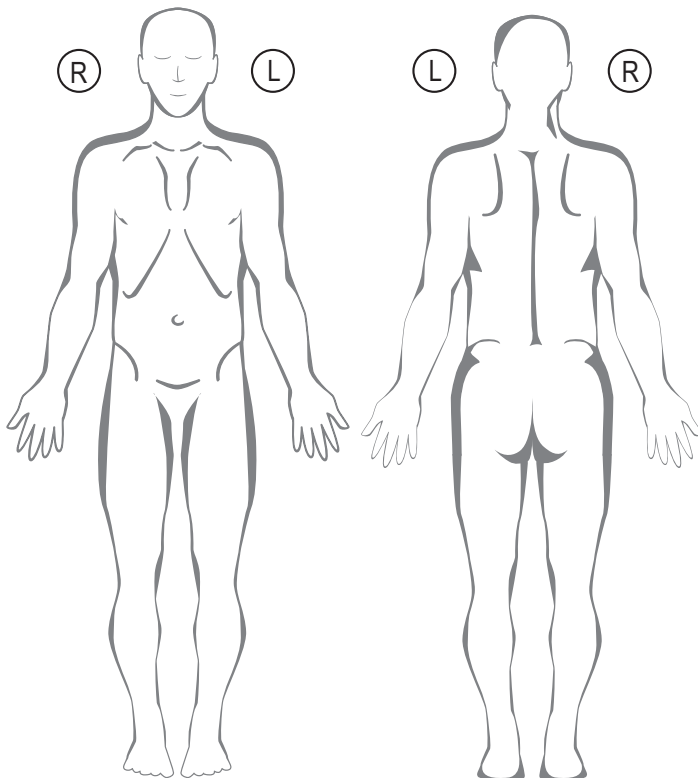
List any Relevant Surgeries with Dates: _____

Patient Name: _____ Date: _____

Description of Pain - Circle all that apply

Aching Burning Consistent Dull Pinching Occasional Sharp Throbbing

Draw the Painful Areas on the Body



Functional Status

Have you had any falls in the past 12 months? ☐ Yes ☐ No

If yes, how many? _____

Did any of these falls result in injury? ☐ Yes ☐ No

Employment

Occupation: _____

Work Status:

- ☐ Full time
- ☐ Part time
- ☐ Unemployed
- ☐ Full time student
- ☐ Part time student
- ☐ Retired

Current Ability to Work:

- ☐ Can perform all duties
- ☐ No formal restrictions
- ☐ Restricted duties
- ☐ Is off work
- ☐ Is on temporary disability

Restrictions: _____

Current Capabilities

Rate these Activities on how you are Currently Able to Perform Them:

	<u>Always</u>	<u>Sometimes</u>	<u>Never</u>
Sitting for extended periods	☐	☐	☐
Standing for extended periods	☐	☐	☐
Repetitive bending	☐	☐	☐
Repetitive lifting	☐	☐	☐
Lifting moderate weights	☐	☐	☐
Lifting heavy weights	☐	☐	☐
Operating heavy equipment	☐	☐	☐
Driving	☐	☐	☐
Typing/Computer operation	☐	☐	☐
Walking	☐	☐	☐

Authorization for Treatment

I authorize the therapists of Capstone Physical Therapy to administer such treatment as is prescribed and considered therapeutically necessary on the basis of findings during the course of treatment. The information provided is accurate to the best of my knowledge.

Signature: _____ Date: _____

Please list ALL medications (including prescription, over-the-counter, herbals, vitamins, minerals, dietary or nutritional supplements) which you may be taking routinely and / or on an as needed basis.

If you have too many medications to list on this page, or are not sure about the details, please inform the patient care coordinator at your clinic so we can contact your primary care physician. If you have a copy of your medication list, please provide it to the patient care coordinator so that you do not need to fill out this page.

Medication	Dosage	Times Per Day	Route (oral, injection, etc)
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____
9. _____	_____	_____	_____
10. _____	_____	_____	_____
11. _____	_____	_____	_____
12. _____	_____	_____	_____

Allergies

Please list any allergies: _____

Imaging

Diagnostic Testing - Circle any that apply and are relevant to your current condition:

MRI X-Ray Bone Scan CT Scan EMG NCV Other: _____

Imaging Facility: _____

Signature/Guardian's Signature: _____ Date: _____

This information has been reviewed with the patient/guardian to confirm accuracy. Therapist Initials: _____



Notice of Privacy Practices

Acknowledgement of Receipt

Check one box:

- ☐ I acknowledge being offered a copy of the Notice of Privacy Practices and have chosen to take a copy for my personal records.
- ☐ I have been offered a copy of the Notice of Privacy Practices for Capstone Physical Therapy, but I have chosen to decline a copy at this time.

Communication Preferences

Check all that apply:

- ☐ In addition to those described in the Privacy Policy, I give my permission for CPT to discuss my health care and billing information with the following people:

Name: _____ Relationship: _____ Contact Info: _____

Name: _____ Relationship: _____ Contact Info: _____

Name: _____ Relationship: _____ Contact Info: _____

- ☐ Phone: I give CPT permission to leave a detailed message on my voicemail/ answering machine.
- ☐ Email: I give CPT permission to send me email messages regarding my care, educational newsletters and upcoming clinic events. *(We will not sell or distribute your email address to any other entity.)*
- Email address: _____

Patient or Guardian Signature

Print Name

Date

How did you hear about us? - Circle any that apply

Primary Care Physician

Specialist

Family

Friend

Radio

Other - specify below

Thank you for choosing Capstone Physical Therapy!