capstone physical therapy

Financial Policy

Deductible $ _____ / $ _____ met

Co-pay/coinsurance _____

Out of pocket $ _____ / $ _____ met

Date Verified: _____

☐ N/A - no patient responsibility

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.

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*

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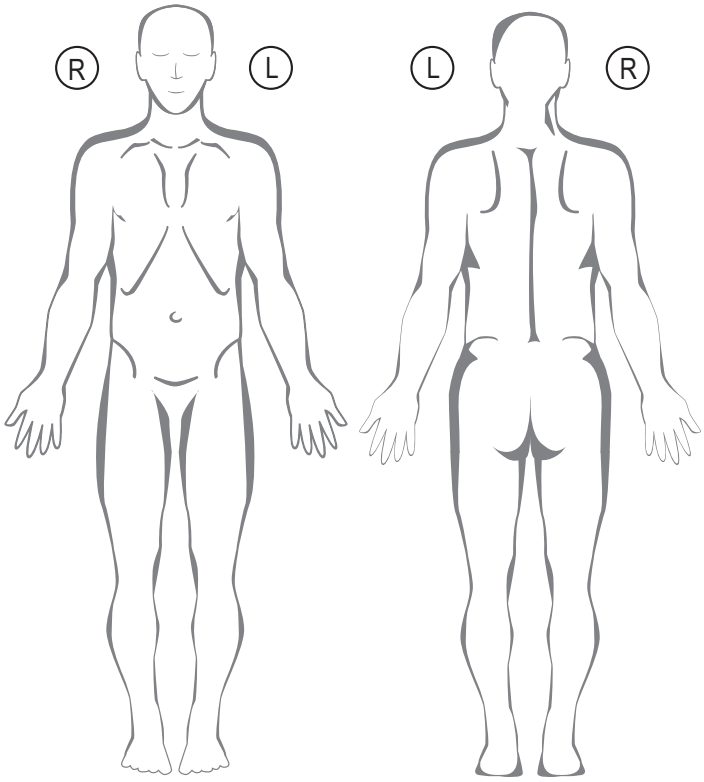
Health History Form

Description of Pain - Circle all that apply

Aching Burning Consistent Dull Pinching
Occasional Sharp Throbbing

Draw Draw the Painful Areas on the Body



Fall History

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

Pain Behavior

What is the worst your pain has been? 0 1 2 3 4 5 6 7 8 9 10

What is your current pain level? 0 1 2 3 4 5 6 7 8 9 10

What is the best your pain has been? 0 1 2 3 4 5 6 7 8 9 10

What activities make you better? _____

_____

What activities make you worse? _____

_____

Goals

What are your goals with therapy? _____

_____

_____

Previous treatment: _____

_____

_____

BMI

Height: _____ ' _____ Weight: _____ lbs

Surgical/Imaging History

List any relevant surgeries with dates: _____

_____

_____

Diagnostic Testing - Circle any that apply:

MRI X-Ray Bone Scan CT Scan

EMG NCV Other: _____

Imaging Facility: _____

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: _____

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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!