capstone physical therapy

Financial Policy

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. Payment in full may be due at the time of service depending upon services requested.
- We accept cash, checks, & credit cards.

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. Please advise our clinic of any changes or updates in address, insurance, phone, new injury or employment changes to ensure accurate billing.

- **Medicare:** As of January 1, 2006, Medicare has a dollar amount soft cap for outpatient Physical & Occupational Therapy benefits. If you have a supplement plan, it may provide coverage beyond this cap.
- **Workers Compensation Claims:** Please provide the office the name and phone number of your claims representative before your begin treatment. We require your private information at the time of service. If your claim is not accepted, we will bill your private insurance.
- **Motor Vehicle Collisions:** We will bill your Personal Injury Protection (PIP) as a courtesy to you. However, you are fully responsible for the bill. We require your private information at time of service and will bill your insurance in the event that payment has not been made within 60 days.
- **Private Pay/No Insurance:** Full payment is due at the time of service.

Doctor Referrals: 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.

High Deductibles: If your insurance plan requires you to meet your deductible before it will cover your visit, Capstone will collect a $120 payment up front towards the visit amount. Estimated visit costs range between $120 - $250 depending on insurance plans and what services are provided.

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 canceled with less than 24-hours notice, there is a $55 cancellation fee that will be your 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.

Patient balances are due upon receipt of statement. Unpaid balances older than 30 days will have a 10% interest rate applied.

_____
Initial

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.

Notice of Privacy Practices

I have been offered a copy of the Notice of Privacy Practices.
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: _____

I give CPT permission to leave/send detailed messages regarding my care: ☐ Voicemail ☐ Email

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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 Notice of Privacy Practices and agree to the terms therein.

Signature of Patient or Responsible Party *Print Name* *Date*

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Health History Form

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

Other Conditions Not Listed Above: _____

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

Surgical History

List any Relevant Surgeries with Dates: _____

_____

Patient Name: _____ Date: _____

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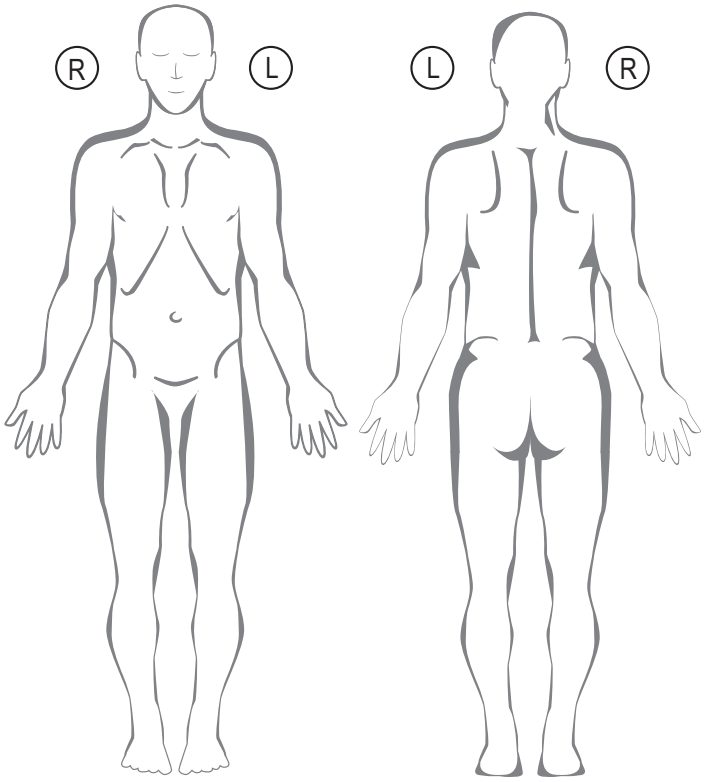
Health History Form Part 2

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:

	Always	Sometimes	Never
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: _____

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Medications, Allergies & Diagnostic Testing

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 Initals: _____

CONSENT TO USE ARTIFICAL INTELLIGENCE SCRIBE TECHNOLOGY

Patient Name**:** _____ Date of Birth: _____

I acknowledge that _____ Clinic ("Provider") will be using an artificial intelligence (AI) scribe software service ("Software") during my physical therapy visits. This Software will create notes in real-time, allowing my Provider to focus on me and less time on documenting our therapy encounter.

By initialing and signing this **Consent to Use Artificial Intelligence (AI) Scribe Technology Form**, I expressly certify that I understand:

_____ 1. Provider will be using the Software service to capture conversations between Provider and myself to auto-generate Provider's documentation and administrative work.

_____ 2. The Software will process an audio recording of the conversation between Provider and me and will record my protected health information to auto-generate Provider's draft note.

_____ 3. The provider will use the draft note to document and sign the final note that becomes part of my electronic medical record.

_____ 4. The audio recording will be stored securely after Provider has finalized and signed the note and transferred it to my electronic medical record. The audio recording will be stored in accordance with the security regulations of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA").

_____ 5. The audio recording of my protected health information will be used for clinical purposes, only, which includes treatment, payment, or health care operations in accordance with HIPAA. It will not be used for any other purposes.

_____ 6. I may revoke this Consent at any time by giving written notice to Provider, except to the extent that Provider and its agents, employees, and representatives may have taken prior action in reliance on this Consent.

I have read all the information above, or it has been read to me. I have had the opportunity to ask questions about the Software, and any questions I have asked have been answered to my satisfaction. By initialing the above statements and signing below, I expressly consent to use the Software and to have my visits recorded to support my Provider's clinical work.

_____ _____

Patient Signature Date

_____

Parent/Legal Guardian (If Patient is a Minor)