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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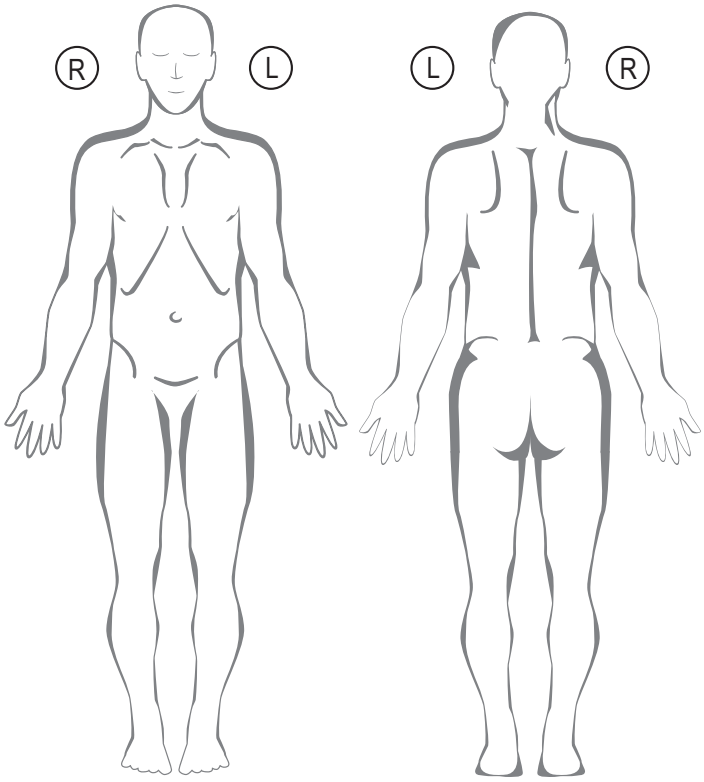
Health History Form

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: _____