

Patient Information

Patient Name: _____ **Gender:** M F

SSN: _____ Marital Status: Single Married Divorced Widowed Minor

DOB: ____/____/____ Home Phone: (____) ____ - ____ Cell Phone: (____) ____ - ____

Address: _____

City: _____ Referring Physician: _____

State: _____ Zip Code: _____ Family Physician: _____

E-mail Address: _____ Occupation/Position: _____

Emergency Contact: _____ Phone: (____) ____ - ____

Employer/School: _____ Work Phone: (____) ____ - ____

Is the patient the subscriber of the policy?
YES or NO (If NO, please complete below.)

Is the patient the subscriber of the policy?
YES or NO (If NO, please complete below.)

Insurance Information

Primary Insurance: _____ **Secondary Insurance:** _____

Policy #: _____ Policy #: _____

Group #: _____ Group #: _____

Is the patient the subscriber of the policy?
YES or NO (If NO, please complete below.)

Is the patient the subscriber of the policy?
YES or NO (If NO, please complete below.)

Subscriber's Name: _____

Subscriber's Name: _____

Subscriber's DOB: _____

Subscriber's DOB: _____

Relationship to Patient: _____

Relationship to Patient: _____

Subscriber's SSN: _____

Subscriber's SSN: _____

My condition is related to (Check One): Work Auto Accident Other None

If Auto or Work Related: Date of Injury/Accident: ____/____/____ Claim #: _____

Contact Person: _____ Telephone #: (____) ____ - ____

Employer Name: _____ Telephone #: (____) ____ - ____

Address: _____

Keith L. Good, P.C.
Financial Policy
Consent for Release of Information
Notice of Privacy Practices

I hereby understand the need to attend physical therapy at the frequency of visits determined by my physical therapist along with my doctor in order to optimize my improvement and health.

Consent for Treatment

I hereby given written consent for physical therapy treatment. I understand and authorize Good Physical Therapy to furnish treatment which is considered to be necessary and proper in treating my condition.

Initials _____

Financial Responsibility

I agree to be financially responsible for the physical therapy treatment provided to me by Good Physical Therapy. I have read and understand the financial policy as set forth by Good Physical Therapy and understand that at any time this policy may be amended by the practice without prior notice to the patient, but notification to come within thirty (30) days of the amendment.

Initials _____

Assignment of Benefits

I hereby authorize payment directly to Good Physical Therapy (Keith L. Good, P.C.) any benefits payable to me and/or my qualified dependents under the insurance coverage provisions identified on bills submitted by Good Physical Therapy for treatment.

Initials _____

Consent for Release of Information

I understand the Good Physical Therapy may need to disclose certain protected health information about me to carry out treatment, payment, and healthcare operations. I authorize Good Physical Therapy to release my protected health information only as deemed necessary and appropriate for my care and only to necessary parties, such as my health insurance, physician, and any durable medical suppliers should the need arise. By signing this document, I also give Good Physical Therapy permission to leave a voice message if I am unable to answer any telephone calls directly regarding my physical therapy course of treatment.

Initials _____

Co-Payments

I understand that if my health insurance plan requires a co-payment for physical therapy services, my co-payment is expected to be collected at the time of service unless prior arrangements are made directly with the billing manager.

Initials _____

Acknowledgement of receipt of privacy practices and authorization

I hereby acknowledge that I have received and/or reviewed a copy of Good Physical Therapy's Notice of Privacy Practices.

Initials _____

I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE ABOVE AND HAVE PROVIDED GOOD PHYSICAL THERAPY WITH MY INFORMATION TO THE BEST OF MY KNOWLEDGE.

Signature of Patient or Responsible Party

Date

Please print Name of above Person

Guarantor Information

Patient Name: _____

Guarantor: _____

Address: _____

City *State* *Zip Code*

Phone Number: _____

Guarantor's Social Security Number: _____

Guarantor Date of Birth: ____/____/____

Relationship to patient: _____

This information is necessary only for children who are under a parent or guardian's health insurance, and if the person responsible for any expenses, such as copays, deductibles, or coinsurance is someone other than the patient.

Good Physical Therapy Attendance Policy

At Good Physical Therapy we strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your wellbeing and restoration of your physical abilities is something our entire staff takes quite seriously.

Because we care so much about your progress, we realize that it would be a disservice to you (including your doctor & insurance company) if we did not emphasize the importance of **YOUR** commitment to the care you need to receive and the actions we ask you to do.

Your adherence to the recommended frequency and duration of treatment is a vital component of your progress with our services; therefore we respectfully request you follow your plan of care in order to ensure an optimum result.

In order to optimize your result all parties including physical therapy, your doctor and your insurance carrier are expecting you to follow your plan of care and scheduled treatments toward a cost effective approach to the goal of **RESTORING** function as quickly as possible.

Although we are aware that the unexpected does arise, outside those extreme circumstances it is very important to attend all of your appointments. If you need to reschedule an appointment please call our office 24 hours prior. This will allow our staff ample opportunity to reschedule your missed appointment in a timely and therapeutic manner. Failure to do so or a "No Show" is subject to a \$25 service charge. Because insurance companies provide us with strict guidelines of frequency and duration of care, make up appointments need to be scheduled in the same week, preferably the next day.

In the instance of repeated non compliance with your scheduled visits both you and the provider (Good PT) are subject to the risk of noncovered services due to lack of consistency and limited restorative capabilities of our services. As indicated in our Financial Policy, the patient becomes responsible for non covered services. We would prefer not to send you a bill for services denied due to inconsistent or interrupted attendance.

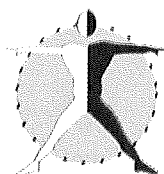
Thank you for your kind consideration of this agreement. Our staff really wants to be "Good" at what we do. That means helping you. We need your help also. We really want you to go back to your doctor with the best possible result. When you look and feel "Good", it makes us look "Good". Please help us live up to our name.

Thank you sincerely for your help!

The Entire Staff at Good Physical Therapy

[] I understand and agree with the purposes of this policy

Signature: _____ Date: _____



Good Physical Therapy – Kenhorst

PATIENT HISTORY QUESTIONNAIRE

Name _____ Date _____

Date of Birth _____ Age _____ Occupation _____

Referring Physician _____ Next Appointment Date _____

Primary Care Physician _____ Involved Area of Body _____

What is the condition for which you were referred to PT? _____

Have you ever been hospitalized for this condition? Yes _____ No _____
 If yes: Dates Hospitalized _____ Length of Stay _____ Hospital _____

Have you ever had Physical Therapy or Chiropractic care for this condition? Yes _____ No _____
 If yes: Dates of Treatment _____ How Long _____ Location _____

Have you had any diagnostic tests for this condition? (Example: X-ray, MRI, CT scan, NCV/EMG)
 Yes _____ No _____ If yes: List _____

List any medications you are taking for this condition _____

List any medications you are taking for any other conditions _____

List any allergies you have _____

What was the cause of your symptoms? (Example: Work injury, car accident, sports, etc.)

Onset date of your symptoms _____ Present pain scale (0 – 10) _____

Activities that increase your symptoms (Example: Sitting, standing, etc.) _____

Activities that decrease your symptoms (Example: Lying down, walking, etc.) _____

Goals or expectations of Physical Therapy _____

Mark an 'X' beside any condition you currently have or previously have had, with date and details

X	CONDITION	DATE AND DETAILS	X	CONDITION	DATE AND DETAILS
	Asthma			Cancer	
	High Blood Pressure			Stroke	
	Heart Disease			Diabetes	
	Lung Disease			Fractures	
	Kidney Disease			Arthritis	
	Vascular Disease			Surgeries	
	Infectious Disease			Headaches	
	Vision/Hearing Loss			Seizures	
	Current Pregnancy			Pacemaker	

Medical Issues noted listed: _____

KEITH L. GOOD, P.C. FINANCIAL POLICY

Good Physical Therapy is dedicated to providing our patients with the best possible care and services while keeping the costs to you from increasing at an unreasonable rate. We ask your help by understanding and cooperating with our financial policy.

****I hereby authorize my insurance benefits (including Medicare and Medigap benefits) to be paid directly to Good Physical Therapy. I also authorize this office to release any information to all relevant parties required in the payment of my claim.**

INSURANCES: We participate with several insurance companies. Please check with the billing department to see if we participate with your plan. UNDERSTAND THAT WE VERIFY HEALTH INSURANCE AS A COURTESY TO THE PATIENT, AND THE INFORMATION WE RECEIVE MAY NOT BE ACCURATE.

****If we DO participate with your insurance company, all services performed in our office will be submitted to your insurance carrier. All copays are your responsibility and are due at the time of service. Deductibles and co-insurances are also your responsibility and will be billed to you after we receive payment from your insurance carrier.**

****Per Medicare regulations, claims for therapy services above the therapy cap which are in turn represented as "benefit category denials", will then be the responsibility of the beneficiary/patient.**

****HMO and POS insurance may require referrals for services. It is the patients' responsibility to obtain the referral prior to the time of service and to bring it with you to your first visit. If a referral is NOT present at the time of service, the patient will be rescheduled or has the option to keep the appointment with the understanding that you will be totally responsible for payment for this visit, and payment will be due at the time of service.**

****If we DO NOT participate with your insurance company we will as a courtesy submit for you, however, anything that is not covered by your insurance will be your responsibility and due within thirty (30) days after receiving our bill.**

****AUTO ACCIDENT:** We accept auto insurance payments including your benefits under PIP (Personal Injury Protection). It is your responsibility to provide us with this important information as well as your signature (and your attorney's information) on the Patient Information Sheet.

****WORKER'S COMPENSATION:** We will send appropriate claim forms for services rendered on your behalf. If and when a claim is denied, we will expect payment from the patient within thirty (30) days of receipt of our bill. If the patient has other insurance options, Good Physical Therapy will cooperate whenever possible in assisting the patient in his/her efforts to be reimbursed from that source.

**** With both cases mentioned above, it is beneficial to you to also provide our office with your regular health insurance. This is necessary in the case that auto or worker's comp does not pay, so that all rules of all insurances involved can be followed in accordance to their regulations.**

IT IS IMPORTANT FOR YOU TO UNDERSTAND THAT YOUR HEALTH INSURANCE COVERAGE IS AN AGREEMENT BETWEEN YOU AND YOUR INSURANCE COMPANY AND IT IS NOT THE RESPONSIBILITY OF GOOD PHYSICAL THERAPY SHOULD ANY INFORMATION RECEIVED BE INCONSISTENT.

PAYMENT FOR SERVICES: Our office accepts Visa and MasterCard for your convenience, as well as cash and checks. All payments are expected at the time of service unless other arrangements have been made prior to your visit. Payment for any outstanding balances are due within thirty (30) days. Payment plans are accepted, feel free to contact the billing department. All past due balances that exceed 60 days with no activity indicating payments received, will be subject to a 12.5% interest charge monthly until paid in full. Returned checks will be subject to a \$25.00 fee payable immediately upon notice.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY GOOD PHYSICAL THERAPY AND I AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF THE FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTICE TO THE PATIENT BUT NOTIFICATION TO COME WITHIN 30 DAYS OF THE AMENDMENT.

A COPY OF THIS WILL BE GIVEN TO YOU. A SIGNATURE PAGE WILL BE USED AS AN AFFIRMATION OF YOUR REVIEW AND UNDERSTANDING OF THIS POLICY.