

Physical Therapy of Boulder, P.C.

Patient Information

Name: _____	Home Phone # () _____
Address: _____	Work Phone # () _____
City: _____ State: _____ Zip _____	Cell Phone # () _____
Date of Birth: _____	Email Address: _____
Gender: FEMALE MALE	Emergency Contact: _____
Employer: _____	Phone # () _____
	SSN: _____
	Marital Status: Single Married Other
	Is this injury work related? Yes No
Name of Referring Doctor: _____	Date of Injury: _____
	Workers Comp Injury: Yes No (If yes, Employer Name)
Referring Provider Phone # _____	
	Auto Injury: Yes No If yes, what state? _____
Address: _____	Is your case in litigation? Yes No
	Attorney's Name & Phone # _____

I authorize the release of any medical information necessary to process this claim.

I, the undersigned agree, whether signing as agent, of patient, that in consideration of the services rendered to the patient, to be individually obligated to pay the bill. Should the account be referred to an attorney for collection, I shall pay reasonable attorneys fees.

I hereby assign payment directly to Physical Therapy of Boulder, **BASIC BENEFITS** and/or **MAJOR MEDICAL (catastrophe) BENEFITS** herein specified and otherwise payable to me but not to exceed the regular charges for this period of treatment. I understand I am financially responsible for any charges not covered by this assignment.

I understand that upon discharge I may request, in writing, a copy of my records. I have read, understand and signed the Physical Therapy of Boulder, Financial Policy.

Signed _____ (Patient and/or Insured Party) Date _____

Consent for Treatment

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient at Physical Therapy of Boulder.

Signed _____ Date _____

Your Medical History

Name: _____

Age: _____ Height: _____ Weight: _____ M/F

Occupation: _____

Activities Done At Work: _____

Example: sitting, standing, computer work, lifting, etc.

Do you have / or have you had any of the following:

Diabetes	yes/no	Metal Implants	yes/no
High Blood Pressure	yes/no	Pregnant(presently)	yes/no
Heart Disease/Attack	yes/no	Headaches	yes/no
Pacemaker	yes/no	History of Smoking	yes/no
Stroke	yes/no	Seizures	yes/no
Cancer	yes/no	Hernia	yes/no
Kidney Problems	yes/no	Previous Surgeries	yes/no

If you answered yes to any of the above, please explain as necessary:

In the present calendar year have you received any of the following:

Physical/Occupational Therapy Chiropractic/Acupuncture care? Yes/no If yes, which type of treatment: _____

Was your treatment for the present injury or a different injury: If different please explain: _____

Excluding the previous question have you received any physical therapy in the past 5 years? Yes/no if yes, for what: _____

Current Medications: _____

Whom may we thank for referring you to Physical Therapy of Boulder? _____

Name of your family or primary care physician: _____

Patient Signature

Date

PHYSICAL THERAPY OF BOULDER-FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we ask that you read and sign prior to treatment.

WE ACCEPT VISA, MASTERCARD, CASH AND CHECKS.

Regarding Insurance

As a service to you, our billing office will gladly bill your insurance company directly on a weekly basis. Our billing office will also bill supplemental insurance and secondary insurance companies. In order for us to perform this service for you, please provide us with the necessary information specified below:

- If you are using health insurance, we will need to obtain a copy of your insurance card.
- If you were injured in an auto accident, we will need your claim number, auto insurance company, date of accident, and your adjustor's name, date of injury, and your adjustor's name and telephone number.
- If you are being treated for a work injury, we will need a your workers compensation claim number, insurance company, name, date of injury, and your adjustor's name and telephone number.

Your contract for health insurance is between you and your insurance company. We are not a party to that contract. The physical therapy services that you receive and the bill for those services are an agreement between you and Physical Therapy of Boulder (PTB). It is ultimately your responsibility to see that your physical therapy bill is paid in full.

Patient Responsibility for Insurance Verification

Agreements with insurance companies vary greatly, and it is your responsibility to know what is their portion to pay. Any remaining money unpaid by your insurance company will be your responsibility to pay in a timely manner. If your insurance company does not begin paying PTB within 5 weeks, it will be your responsibility to contact them. You will receive a patient bill monthly. It will reflect what your insurance company, upon verification, told us is your portion to pay. We expect this payment within 15 days.

Regarding Insurance Plans Where We are a Participating Provider: All co-pays are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

If you receive a payment made out to both PTB and you, please endorse the check and forward it to us.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary rates. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and medically necessary by the insurance provider.

Minor/Dependent Patients

The parents (or guardians) accompanying a minor or dependent patient are responsible for full payment of the minor or dependent patient's treatment. For unaccompanied minor and dependent patients, non-emergency treatment will be denied unless charges are paid by cash, check, or credit card at the time of service.

Missed Appointment and Cancellation Charges

Because we commonly have a waiting list, **unless cancelled at least 24 hours in advance**, our policy is to charge for missed appointments. **There is a \$ 50 charge for missed appointments cancelled less than 24 hours in advance.** Insurance does not pay this charge. You are financially responsible for this fee. Please help us serve you better by keeping scheduled appointments, or call us in a timely manner to allow another patient to have your scheduled time.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns at any time. I have read the Financial Policy. I understand and agree to this Financial Policy.

Signed _____

Date _____

Printed Name _____

YOUR RIGHTS REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

Subject to limitations outlined by law, you have certain rights related to use and disclosure of your protected health information, including the right to:

- Request restrictions on certain uses and disclosures. However, Physical Therapy of Boulder is not obligated to agree to requested restrictions.
- Receive confidential communications of protected health information.
- Inspect and copy your protected health information with some limited exceptions.
- Amend your health information.
- Receive an accounting of disclosures of your health information.
- Obtain a copy of this notice.

PHYSICAL THERAPY OF BOULDER DUTIES REGARDING THE PRIVACY OF YOUR HEALTH INFORMATION

Subject to limitations outlined by law, Physical Therapy of Boulder is required by law to maintain the privacy of protected health information, including:

- Physical Therapy of Boulder is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.
- Physical Therapy of Boulder reserves the right to abide by the terms of the privacy notice that is currently in effect.
- Physical Therapy of Boulder reserves the right to change a privacy practice described in this notice and to make such change effective for all protected health information. Revised notice will be posted in our office and available upon request.

CONCERNS

If you believe your privacy rights have been violated, you may make a complaint by contacting our Office Manager or the Secretary for the Department of Health and Human Services. No individual will be retaliated against for filing a complaint.

ACKNOWLEDGEMENT

I acknowledge that I have received a copy of this notice regarding the use and disclosure of my health information.

Signature

Date

Printed Name of Patient or Authorized Representative