On Point Physical Therapy, LLC Patient Registration Forms

Patient Information

Patient Name:
Date of Birth: Gender:
E-mail Address:
Phone: Home Cell Work
Address:
How did you hear about us?

Injury Information

Injured area:
Referring Doctor: Date of Injury:

Emergency Contact

Emergency Contact name:
Emergency Contact phone number:

Employment Information

Employer:
Employment Status:
Unemployed Full-Time Part-Time Retired

Insurance Information

Insurance Carrier:
Policy Holder:
Policy Holder DOB:
Policy Number:

On Point Physical Therapy, LLC

Medical History Form

Please describe your current condition, including the history and onset:

Date of surgery (if applicable): Type of surgery:

Diagnostic Tests

Type of test	Date	Results

Past Medical History

Have you ever had any of the following conditions? Check all that apply.

Asthma	Fainting/dizziness	Osteoporosis
Arthritis	Frequent/severe headaches	Peripheral neuropathy
Bowel/Bladder problems	Hearing problems	Seizures/epilepsy
Cancer	Heart Condition	Stroke
☐ Diabetes	High Blood Pressure	Vision problems
Emphysema	☐ Neurological conditions	☐ Other

Have you had any previous surgeries? If so, when?

Have you had any falls in the past year? Yes No

If yes, about how many?

Do you smoke? Yes No

Do you exercise regularly? Yes No How often?

Do you have any known allergies? Yes No

If yes, please list:

Please list any medications or supplements you are currently taking.

Name	Dosage

Signature: Date:

Consent for E-mail/Text Communication and Appointment Reminders

We respect the privacy rights of all our patients and will therefore only communicate with patients and parents/guardians through email, text or voice mail messaging with your written consent. Email can be inherently insecure if your email service does not use encryption. Also, if your email address is through your employer, your employer may have access to your email box. Voice mail may also be insecure, especially if you use a VOIP phone service. When you consent to communicating with us by email, text or phone, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information. Since we do not control the email and phone systems you use, we are not responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you have consented to.

You may choose to limit the type of voicemail, email or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text.

- I do not consent to any voicemail, email or texting communication.
- I consent to receiving communication about the scheduling of appointments (limiting the information disclosed) by the following means: (check all that you consent to)
    - Email
    - Text
    - Voicemail
- I consent to all communication, including but not limited to communication about my medical condition and advice from my health care providers by the following means: (check all that you consent toO
    - Email
    - Text
    - Voicemail

E-mail address: _____

Phone number: _____

Patient Signature: _____ Date_____

Parent/Guardian Signature:_____ Date_____

On Point Physical Therapy

Notice of Privacy Practices Acknowledgement

I acknowledge that I have been given a copy of or an opportunity to read the practice's Notice of Privacy Practices.

_____ _____

Patient's or Guardian's Signature Date

Informed Consent to Treat

Physical Therapy: The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation and intervention by use of rehabilitative procedures, mobilization, manual techniques, exercises, and physical agents to aid the patient in achieving their maximum potential and to accelerate recovery. All procedures will be thoroughly explained to me before they are performed.

Informed Consent for Treatment: The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. I understand that the physical therapist provides a wide range of services and I will receive information at the initial visit concerning the treatment and options available for my condition. I will notify my practitioner if I am pregnant, become pregnant, or am trying to get pregnant. I understand I am encouraged to communicate with a physician the potential benefits and risks of treatment relevant to my pregnancy.

Potential Benefits: Benefits may include an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Potential Risks: I may experience an increase in my current level of pain or discomfort, or aggravation of my existing injury during physical therapy. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist.

No Warranty: I understand that my physical therapist cannot make any promises or guarantees regarding a cure for or improvements in my condition. I understand that my physical therapist will share with me their opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Name (please print): _____

Signature: _____ Date: _____

Payment Agreement

Thank you for choosing On Point Physical Therapy, LLC as your physical therapy provider. Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

- You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.
- Payment is expected at time of service unless you have made other payment arrangements with us.
- Out-of-Network Policy. (Commercial Health Plans - Does not apply to Medicare) We are out-of-network with all health plans. If you have out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. You understand that even if you have out of network benefits, you may be required to pay a higher copay or coinsurance for out of network services and you may have separate out of network deductibles and out of pocket maximums. You are responsible for contacting your insurance company to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.
- TriCare. We are not in-network with TriCare and are not willing to accept TriCare's low reimbursement rates. Therefore, if you have TriCare, you should seek services from an in-network TriCare provider or a provider who is willing to accept TriCare's maximum allowable reimbursement. If you wish to see us, you must be willing to forego TriCare reimbursement and choose, of your own free-will, not to use your TriCare benefits. That means, we will not submit claims to TriCare on your behalf and agree not to submit claims to TriCare for reimbursement. If you decide at any point after you start services with us that you want TriCare to pay for the services it covers, we will be happy to recommend a TriCare enrolled provider and terminate your services with us.
- Medicare Policy (for Medicare Part B and Medicare Advantage Plans). If you are a Medicare beneficiary, you understand that our licensed physical therapists are **not** enrolled as Medicare providers. Medicare has onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide. Since we are not enrolled providers, we cannot submit claims to Medicare **and** Medicare will not pay for our services even though the same services might be paid by Medicare if you obtained them from a Medicare enrolled provider. If you want Medicare to pay for services that might be considered covered benefits, you should seek those services from a Medicare enrolled provider. If you decide at any point after you start services with us that you want Medicare to pay for the services it covers, we will be happy to recommend a Medicare enrolled provider and terminate your services with us. As a condition of us providing services to you, you are choosing, of your own free will, not to use your Medicare benefits and agreeing to pay privately at the time of service for all services you elect to receive from us with no expectation that Medicare will reimburse you. You understand that we will not submit claims to Medicare on your behalf and agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare for reimbursement.
    - Medicare supplemental or secondary insurance plans. If your Medicare supplemental or other secondary insurance plan will reimburse you for medically necessary services by providers not enrolled with Medicare, we will provide you with a Superbill that you can send to your supplemental or secondary plan to see if they will reimburse you without a Medicare denial. We cannot submit a claim to Medicare just to get a denial since we are not enrolled as a Medicare provider. You should also be prepared that some supplemental plans will not reimburse for services by providers who are not enrolled with Medicare.
    - Medicare as a Secondary Payer. If you have a commercial insurance plan, we will provide you with a copy of your bill that you can, at your discretion, submit to your commercial health plan for reimbursement for the services your health plan covers. However, since we are not Medicare enrolled providers, Medicare will not pay your copays, co-insurance or deductibles as a secondary payer. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare for reimbursement of copays, coinsurance or deductibles that your commercial health plan does not pay.
- Cancelation Policy. We require a 24-hour notice to cancel a scheduled appointment. If you cancel with less notice, you will be required to pay a **$75** late cancelation/no show penalty fee. We reserve the right to waive this policy at our sole discretion.
- Privacy Rights. You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. If you pay for your services at the time of service, we assume you are exercising this right to privacy we will not disclose your medical records to any third party, including your health insurance carrier or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Authorization to Release Protected Health Information form before we will disclose your health information.
- Appeals Policy. You understand that you are responsible for filing all appeals of adverse benefit determinations. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.

I HAVE READ, UNDERSTAND AND AGREE TO THESE PAYMENT TERMS.

I acknowledge that I have chosen, of my own free will, to obtain the services provided by On Point Physical Therapy, LLC and have agreed to pay out of pocket for my services without any expectation that my health plan will reimburse me. If I am a Medicare beneficiary, I attest that I have chosen not to use my Medicare benefits for the services I am purchasing and am restricting On Point Physical Therapy, LLC and my therapist from submitting any claims to Medicare pursuant to my right to privacy under HIPAA.

Patient Name (Print or Type): _____

X _____ Date: _____

Patient's Signature

A photocopy of this agreement is to be considered valid, the same as if it was the original.