SUMMIT PHYSICAL THERAPY AND REHABILITATION

PERSONAL INFORMATION / PLEASE COMPLETE ALL SECTIONS

FIRST & LAST NAME:	CELL PHONE:	HOME PHONE:
ADDRESS:	CITY:	ZIP CODE:
EMAIL ADDRESS:	DOB:	SEX: (Please circle) **M** **F**
EMPLOYER:	WORK PHONE:	OCCUPATION:
REFERRED BY:	SSN:	MARITAL STATUS: **M** **S** **D** **Sep.**
EMERGENCY CONTACT:	PHONE:	RELATIONSHIP:

WORKER'S COMPENSATION / AUTO INSURANCE

If we are filing with your general health insurance and you have provided us with a copy of your insurance card, you do not need to fill out the following section. However, if your injury was due to a motor vehicle accident or work injury, the following section is required.

INSURANCE COMPANY:	PHONE NUMBER: (Include extension number)
ADJUSTOR'S NAME:	FAX NUMBER:

BILLING ADDRESS:	CITY:	ZIP CODE:

CLAIM NUMBER:	DATE OF INJURY:
PLACE OF ACCIDENT:	IS THIS WORK RELATED? (Please circle) **YES** **NO**

I understand and agree (regardless of my insurance status), that I am ultimately responsible for the balance of my account for any professional services rendered. I am also responsible for recognizing insurance status, including, but not limited to, benefits and allowable visits. I have read all the information on this page and certify that the information I provided is true and correct to the best of my knowledge. I also agree to notify Summit Physical Therapy and Rehabilitation of any changes in the above information.

_____ _____

SIGNATURE: DATE:

_____ _____

PARENT OR GUARDIAN: (if minor) DATE:

MEDICAL HISTORY

1. What are you being seen for today?
   _____

2. Who is your referring physician?
   _____

3. When was the onset of your symptoms/injury? (Please indicate date) ___ / ___ /____.

4. Has a physician ever warned you against exercise? ◯ Yes ◯ No
   If yes, please explain: _____.

5. Are you currently engaged in any form of regular exercise? ◯ Yes ◯ No
   If yes, please explain: _____.

6. Are you currently employed full-time? ◯ Yes ◯ No
   If yes, please list any limitations: _____.

7. Have you ever been diagnosed by a physician with the following? (Please circle)

Cancer	Cardiac Disease	Respiratory Disease	High Blood Pressure
Diabetes	Epilepsy	Fibromyalgia	Myofascial Pain
Chronic Fatigue	Arthritis	Osteoporosis	

8. Have you experienced any of the following symptoms in the past month? (Please circle)

Dizziness or Fainting	Illness or Fever	Nervousness
Unexplained Weight Loss	Abdominal or Chest Pain	Severe Fatigue

9. Are you pregnant? (Females only) ◯ Yes ◯ No

10. Please list any medical conditions not mentioned above:_____.

11. Please list all current medications: _____.

12. Have you ever been treated by a Physical Therapist for this injury? ◯ Yes ◯ No

13. Are you undergoing, or have you undergone any other treatment for this injury?
◯ Yes ◯ No If yes, please explain: _____.

I certify that the above information is correct and accurate to the best of my knowledge:

_____ _____ _____

PLEASE PRINT NAME: SIGNATURE: DATE:

CONSENT FOR TREATMENT:

I hereby give my permission for Summit Physical Therapy and Rehabilitation to render treatment to me/my dependent. I understand that I will be given all available pertinent information prior to the treatment being rendered. I will be given the opportunity to ask questions and have all of them answered to my satisfaction. I understand that I may decline treatment at any time.

_____ _____

SIGNATURE: DATE:

CONSENT TO RELEASE/OBTAIN MEDICAL INFORMATION:

Permission is hereby granted to Summit Physical Therapy and Rehabilitation to release information to my insurance company, employer, attorney, worker's compensation carrier, physical/facility referred to for further treatment and/or my referring/family physician. Permission is hereby granted to any facility where I have previously been treated to release medical records to Summit Physical Therapy and Rehabilitation.

_____ _____

SIGNATURE: DATE:

AUTHORIZATION FOR PAYMENT OF BENEFITS:

I authorize Summit Physical Therapy and Rehabilitation to bill my health insurance for services rendered. All payments will be applied to my balance. I will be responsible for all co-pays/co-insurance and deductibles that may apply. Although Summit Physical Therapy and Rehabilitation will help verify and assist me in understanding my benefits, it is ultimately my responsibility, and I will not hold Summit Physical Therapy and Rehabilitation responsible for any misinterpretation of insurance benefits. I understand that any charges not paid by my insurance company are my responsibility, are due and payable by me.

_____ _____

SIGNATURE: DATE:

MEDICARE PATIENT ONLY:

I authorize payment of Medicare benefits to Summit Physical Therapy and Rehabilitation for services rendered, and I authorize the release of medical information to CMS (Centers of Medicare and Medicaid Services) and/or its agents.

_____ _____

SIGNATURE: DATE:

Notice of Privacy Practice Patient Acknowledgement

I have received and/or reviewed this patient's Notice of Privacy Practices. The notice provides details about uses and disclosures of my protected health information that may be needed by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information. I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at or controlled by the practice. I understand that I may obtain this practice's current Notice of Privacy Practices upon request.

CONSENT FOR MASSAGE THERAPY

- The unclothed body will be properly draped at all times for your warmth, sense of security, and a mark of massage professionalism.
- Forced attention and manual therapy will be given as agreed upon by the therapist and client for the predetermined goals of stress reduction, relief of muscular discomfort, and/or health therapy. I have been given an opportunity to ask questions.
- I as a client to provide complete and accurate health information and notice of health changes at successive appointments as appropriate.
- I understand that massage therapy is designed to be an ancillary health aid and is not primary health care treatment.
- Written referral is requested from your primary care provider if:
    - You are currently receiving care.
    - You have a specific medical condition or symptoms for which you take medication or receive periodic evaluation or treatment.
- I will immediately inform my therapist of any unusual sensation or discomfort, so that the application of pressure or strokes may be adjusted to my level of my comfort.
- I understand that this is a professional massage, is therapeutic in nature and is performed by a trained state-licensed therapist.
- I understand that by signing this form, I give consent to receive the treatment discussed in all future sessions and agree that my presence at subsequent session shall be constructed to validation of this written consent.
- I have read this form and hereby freely give my permission to receive massage therapy.
- **I understand that the massage is not sexually oriented in any way and that any illicit or suggested remarks or behavior on my part will result in immediate termination of the session.**

MASSAGE CANCELLATION POLICY

We understand that unanticipated events happen occasionally in everyone's life. In our desire to be effective and fair to all our patients and out of consideration for therapists' time, we have adopted the following policies due our limited availability for appointments:

- 24-hour advance notice is required when canceling an appointment. A $50 fee will be applied to your account if an appointment is missed/cancelled and cannot be filled.
  _____ **I understand and accept this policy.**

- Appointment times have been arranged specifically for you. If you arrive late your session may be
  shortened in order to accommodate others whose appointments follow yours. Your therapist can accommodate a maximum of 15 minutes late for your appointment. After that, we will need to reschedule your appointment.

Printed Name:_____ Date:_____

Signature: _____

Insurance Information:

Primary Insurance: _____ Policy/ID #_____

Policyholder's Full Name: _____ D.O.B: _____ Relationship to Patient: _____

Secondary Insurance: _____ Policy/ID # _____

Policyholder's Full Name: _____ D.O.B: _____ Relationship to Patient: _____

Tertiary Insurance: _____ Policy/ID # _____

Policyholder's Full Name: _____ D.O.B: _____ Relationship to Patient: _____

Financial Policy Statement

We are committed providing the highest level of medical care to our patients. To ensure that our patients fully understand our billing process, we ask that you read and sign this financial policy statement.

Patient Responsibility: It is the responsibility of the patient to pay his/her co-payment, co-insurance, any unpaid portion of the deductible, or non-covered service, at the time of service. Any additional co-payments, deductibles, co-insurance, and/or non-covered service will be billed to the patient as indicated by your insurance by your insurance carrier on their Explanation of Benefits (EOB). Your insurance company will mail you an EOB outlining the services rendered and the portion of the bill which is your responsibility. All patients without insurance must pay in full at the time services are rendered unless other arrangements are made.

Payment Options: For your convenience we offer a variety of payment options. We accept Visa and Mastercard, Personal Checks, Cashier/Bank checks, Money Orders, and of course CASH. All returned checks will be assessed a $30.00 returned check fee in addition to the original charge. A written payment plan may be established in cases of financial hardship.

Insurance Coverage: While we make a good faith attempt to verify your coverage, we are not able to guarantee that the benefits quoted to us by your insurance are correct nor, do they guarantee payment for the services rendered. It is your responsibility alone to know what insurance plan you are on, supply us with the correct information at the time of your visit, and know what services may or may not be covered by your insurance. We encourage you to refer to your benefits manual or call your insurance if you have any questions about covered services. Be aware that some and perhaps all the services provided may not be covered by your insurance. You will be responsible for payment of all non-covered services at the time they are rendered.

Insurance Payments: Your insurance policy is a contract between you and your insurance company, NOT between Summit Chiropractic and Physical Therapy Fairbanks, and your insurance company. **Be assured our billing agent works diligently to obtain payment from your insurance company.** However, if we file your insurance, and the claim has not been paid for any reason within 90 days or if you suspend or terminate your schedule of care as prescribed by Summit Chiropractic & Physical Therapy, we require that you pay the balance using one of the approved payment methods without exception. If your insurance pays us after that time, you will be reimbursed.

Denied Claims: Our billing agent will not become involved in disputes between you and your insurance company regarding uncovered charges, coordination of benefits issues, eligibility issues, pre-existing conditions, or any other matter that is your responsibility, which causes the claim to be denied. Should your claim be denied for any of these reasons, or any other reasons listed here, the claim will become the responsibility of the patient and payment will be expected immediately.

"On the Job" Injury (Workers' Compensation): If you are injured on the job, you will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance. If you do not provide us with this information, or if benefits are denied, any fees and services are due by you.

Personal Injury or Automobile Accidents: Please notify your auto or personal insurance carrier of your visit to our office immediately. If you do not carry a medical payment policy on your auto or personal injury insurance, please provide us with your private health insurance information and we will bill your insurance for you.

Third Party Payors (Not at Fault Auto or Personal Injury): Please notify our office immediately that this is a third-party payor claim. If an attorney us representing, you inform our billing agent as soon as possible. If you have any medical pay on your auto or personal injury insurance or have private health insurance, please provide us with that information and we will bill your insurance for you. Please notify your auto or personal injury insurance carrier, or private health insurance of your visit to our office immediately. If you do not have any insurance, we will wait for a settlement for up to six months after your care is initiated. Once the claim is settled or if you suspend or terminate care, any fees for services is due by you immediately.

Patient Authorization: I have read, understand, and agree to abide by the terms stipulated above. "I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Workers' Compensation, Auto, Personal Injury, Commercial Insurance, or any other insurance benefits I am entitled to, to Summit Chiropractic and Physical Therapy Fairbanks. I understand that I am financially responsible for all charges whether they are covered or not covered by said insurance. I hereby authorize said assigned to release any information necessary to secure payment on my behalf. I further authorize the use of my signature below on all insurance submissions for services rendered or to be rendered. I agree that a photocopy of this agreement shall be as valid as the original."

_____

Responsible Party Signature | Print Patients Name | Date

_____

Guardian (if patient is a minor) | Signature | Date