ACKNOWLEDGEMENT OF DIRECT ACCESS SERVICES

I, _____, acknowledge that I am seeking treatment at STAR Physical Therapy, Limited Partnership without a prescription for physical therapy.

Please elect one of the following by placing your initials in the appropriate blank:

_____ I acknowledge that I DO NOT have a licensed doctor of medicine, chiropractor, dentist, podiatrist, or doctor of osteopathic medicine treating me for the injury for which I am seeking treatment from STAR Physical Therapy, Limited Parternship;

_____ I am electing direct access to physical therapy services and choose NOT to have a licensed doctor of medicine, chiropractor, dentist, podiatrist, or doctor of osteopathic medicine informed of the initiation of physical therapy treatment;

_____ I am electing direct access to physical therapy services and choose to have the following medical professional informed of the initiation of physical therapy treatment;

Medical Professional's Name _____

Address: _____

Phone Number: _____

_____
Signature

_____
Printed Name

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PHYSICAL THERAPY

Patient Registration

A. PATIENT

Please Print Legibly Account #:

First Name:	**Middle Initial:**	**Last Name:**
Address:		
City:	**State:**	**Zip:**
Home Phone:	**Work Phone:**	**Cell Phone:**
DOB:	**SSN #:**	**Gender:** ❑ Male ❑ Female
E-MAIL:		To receive **Statements via Email** check here ❑
❑ Exclude from **Appointment Reminders**? *(If box checked you will not receive Appointment Reminders)*		
Employment Status: ❑ Employed ❑ Unemployed ❑ Retired ❑ Student ❑ Disabled ❑ Other:		
Employer Name:		

B. EMERGENCY CONTACT

Relationship to Patient: ❑ Spouse ❑ Parent ❑ Child ❑ Grandparent ❑ Sibling ❑ Friend ❑ Other:		
First Name:	**Middle Initial:**	**Last Name:**
Home Phone:	**Work Phone:**	**Cell Phone:**
Preferred Contact Method: ❑ Home Phone ❑ Work Phone ❑ Cell Phone		

C. GUARANTOR / RESPONSIBLE PARTY (fill out if patient is a minor)

Relationship to Patient: ❑ Parent ❑ Grandparent ❑ Legal Guardian ❑ Other:		
First Name:	**Middle Initial:**	**Last Name:**
Home Phone:	**Work Phone:**	**Cell Phone:**

D. ACCIDENT

Was your injury as a result of a Work Related or Auto Accident? ❑Yes ❑No If Yes, ❑Work ❑Auto		
Work Comp or Auto Insurance Name:		
Phone #:	**Policy #:**	**Claim #:**
Adjuster Name:	**Accident Date:**	**Accident State:**

E. INSURANCE (if applicable)

Primary Insurance: (copy of card must be on file) **Check here** ❑ if Name, SSN & DOB same as patient.	
Insurance Name:	
Subscriber (Insured) Name:	
Relationship of Patient to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other	
SSN #:	**DOB** (mm/dd/yy)
Secondary Insurance: (copy of card must be on file) **Check here** ❑ if Name, SSN & DOB same as patient.	
Insurance Name:	
Subscriber (Insured) Name:	
Relationship of Patient to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other	
SSN #:	**DOB:** (mm/dd/yy)

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PHYSICAL THERAPY

Patient Health Questionnaire

Patient Name:	DOB:	Account #:

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on this form. If you do not understand a question leave it blank and your therapist will assist you. Thank you!

❑Occupation _____ ❑Leisure Activities _____

Work activities mostly include *(check all that apply)*

❑ Sitting	❑ Lifting	❑ Use of Computer	❑ Bending
❑ Standing	❑ Walking	❑ Driving	❑ Other

ALLERGIES: List any medication(s) you are allergic to: _____

Are you latex sensitive? ❑ Yes ❑ No List any allergies we should know about: _____

Please check (✓) next to any of the following whose care you're under:

❑ Medical Doctor (MD)	❑ Physical Therapist	❑ Speech Therapist	❑ Osteopath (DO)
❑ Chiropractor	❑ Dentist	❑ Psychiatrist	❑ Other

Date of last physical exam: _____How do you **rate your health**? ❑Excellent ❑Good ❑Fair ❑Poor

Have you seen a physician or a physical therapist for this same problem within the last 3 months? ❑ Yes ❑ No

If yes, please explain:

Have you ever been diagnosed as having any of the following conditions? *(Check all that apply)*

❑	asthma	❑	cancer	❑	high blood pressure
❑	mutliple sclerosis	❑	circulation problems	❑	post menopause
❑	diabetes	❑	depression	❑	epilepsy
❑	hepatitis	❑	heart problems	❑	stomach ulcers
❑	stroke	❑	tuberculosis	❑	rheumatoid arthritis
❑	kidney disease	❑	blood clots	❑	osteoporosis

List additional history:

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following? *(Check all that apply)*

❑	diabetes	❑	cancer	❑	high blood pressure
❑	heart disease	❑	kidney disease	❑	inflammatory arthritis
❑	stroke	❑	depression	❑	other

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

Patient Name:	**DOB:**	**Account #:**

Please check (✓) next to any medication you have taken in the last week and indicate if they are prescribed by a physician.

❑ Aspirin	❑ Anti-inflammatories (Advil/Ibuprofen)	❑ Stomach Ulcer Medications
❑ Tylenol	❑ Vitamin / Mineral Supplements	❑ Herbal Remedies
Please indicate the ones prescribed by a physician:		

Please list any other physician prescribed medication you are currently taking (including pills, injections, and / or skin patches). If more than 6, please attach a list and initial below.

❑ List Attached Patient Initials _____ Therapist Initials _____

1._____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

How much caffeinated coffee or caffeine containing beverages do you drink per day? _____

Tobacco use: How many packs do you smoke per day? _____ For how many years? _____ If you quit, when? _____

How many days per week do you drink alcohol? _____

If one drink equals one beer or glass of wine, how much do you drink ot an average sitting? _____

Do you have any **open cuts, lesions, or wounds**? ❑ Yes ❑ No If yes, where:

Have you **fallen** in the past year? ❑ Yes ❑ No If yes, how many times:

If yes to falling, did you **sustain an injury** as a result of the fall? ❑ Yes ❑ No

Do you experience **frequent episodes** of the following (*check all that apply*)?

❑ Headaches	❑ Dizziness	❑ Nausea	❑ Ear Ringing	❑ Balance Control

Have you noticed a change in your **bowel or bladder frequency or control**? ❑ Yes ❑ No

If yes, please explain:

Do you wear glasses or contacts? ❑ Yes ❑ No

When did your **<u>current</u> symptoms begin**? (*date*)_____/_____/_____ or (*time period*) _____

Have you experienced these **symptoms before** *(please explain below)*?

Do you currently **exercise, play sports,** or **have hobbies** (*if yes, please describe below*)?

How did your **injury occur** or **symptoms begin** (*check all that apply*)?

❑ Accident - Work Related	❑ Bending	❑ Reaching	❑ Lifting
❑ Accident - Motor Vehicle	❑ Gradual Onset	❑ Falling	❑ Other
❑ Accident - Third Party / Liability	❑ No Apparent Reason	❑ Dressing	

Indicate daily **activities you are having trouble with** due to this injury or onset of symptoms (*check all that apply*)?

❑ Sitting _____ minutes	❑ Rising	❑ Lying	❑ Grooming
❑ Standing _____minutes	❑ Turning	❑ Dressing	❑ Bending
❑ Walking _____ feet	❑ Driving	❑ Reaching	❑ Athletics
❑ Sleeping _____ hours	❑ Stairs	❑ Housework	❑ Other

What **treatment & testing** have you received (*check all that apply*)?

❑ Physical Therapy	❑ Bracing	❑ Injection	❑ Medication
❑ Occupational Therapy	❑ Orthotics	❑ Myelogram	❑ Chiropractic
❑ Nerve Conduction Study	❑ CT Scan	❑ MRI	❑ X-Ray

Patient Name:	**DOB:**	**Account #:**

Please check (✓) next to any of the following symptoms you are experiencing that are NEW, UNUSUAL, OR ATYPICAL:

❑	weight loss / gain	❑	eye redness	❑	heart racing in your chest
❑	nausea / vomitting	❑	skin rash	❑	difficulty swallowing
❑	dizziness / lightheadedness	❑	problems sleeping	❑	heartburn / indigestion
❑	fatigue	❑	sexual difficulties	❑	constipation / diarrhea
❑	weakness	❑	night sweats	❑	blood in stool
❑	fever / chills / sweats	❑	hearing problems	❑	problems urinating
❑	recent infection	❑	joint / muscle swelling	❑	urinary incontinence
❑	numbness or tingling	❑	bruising easily / excessively	❑	blood in urine
❑	tremors	❑	excessive bleeding	❑	pregnant
❑	seizures	❑	difficulty breathing	❑	stress at home or work
❑	double vision	❑	regular cough	❑	depression
❑	loss of vision	❑	arm / leg swelling	❑	ear ringing / balance control

Use the following scales to **rate your average symptom level** (*circle the appropriate level for each body part*).
"0" = No Symptoms, "10" = Intense enough to seek emergency assistance

Back: 0 1 2 3 4 5 6 7 8 9 10	**Arm**: 0 1 2 3 4 5 6 7 8 9 10	**Leg**: 0 1 2 3 4 5 6 7 8 9 10
Neck: 0 1 2 3 4 5 6 7 8 9 10	**Hand**: 0 1 2 3 4 5 6 7 8 9 10	**Foot**: 0 1 2 3 4 5 6 7 8 9 10

Please indicate on the chart below *(reference the KEY)*, **where specifically you feel the pain** indicated above:

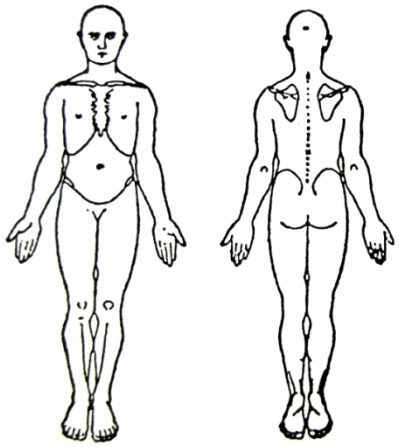
KEY

/ / / / / Stabbing

xxxxx Burning

00000 Pins & Needles

_____ Numbness



What **goals** do you have for therapy? What do you **hope to accomplish**?

Patient / Legal Representative Signature:	**Date:**
Therapist Signature:	**Date:**

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PHYSICAL THERAPY

Consent & Statement of Financial Responsibility

Patient Name:	DOB:	Account #:

CONSENT TO TREATMENT: I consent to rehabilitation and related services at STAR Physical Therapy, LLC. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and / or direct contact of a sensitive nature.

CANCELLATION AND NO SHOW POLICY: We work hard to stay on schedule because your time is valuable to us! Staying on schedule also allows us to provide you with the appropriate amount of time with your therapist to maximize the benefits and give you the best possible outcomes.

Some important reminders regarding your scheduled appointments...

- **24 Hour Notice!** - If you have to cancel an appointment, please try to provide us with at least 24 hours notice.
- **Running Late?** - If you are running late, please call ahead and let us know. If you are running more than 15 minutes late, every attempt will be made to accommodate you. Your treatment may need to be modified or rescheduled in consideration of other patients with already scheduled appointments.
- **Frequent Cancelled or Missed Appointments** - If you regularly cancel or miss your appointments, we may ask that you return to your referring physician prior to scheduling any more therapy.

ACCESS TO AND RELEASE OF HEALTH INFORMATION: I consent to allow STAR Physical Therapy, LLC to use and disclose my protected health information (PHI) within STAR to carry out my treatment, to obtain payment and to carry out health care operation. My PHI may be disclosed to my health plan and/or its agents as necessary to verify benefits, authorize services and process medical claims. My PHI may be disclosed to outside health agencies or institutions involved in my continuing care and / or for emergency care purposes and otherwise permitted or required in the Notice of Privacy Practices.

GUARANTEE OF PAYMENT: In consideration of services rendered to me by STAR Physical Therapy, LLC I hereby guarantee payment for any and all services not covered or allowed by insurance. I also understand that all bills are due and payable upon receipt. I understand that the patient responsibility portion of my bill will be due and payable at the time of service. I understand that should my account with STAR become delinquent and turned over to a collection agency, that I, the undersigned, will be responsible to pay all collection agency fees, court costs or any other fees / costs associated with resolving my account balance.

RETURNED CHECKS: We are happy to accept your personal check; however, if your check is returned for any reason, you expressly authorize your account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. The use of a check for payment is your acknowledgement and acceptance of this policy and its terms and conditions.

ASSIGNMENT OF BENEFITS: I hereby assign STAR Physical Therapy, LLC all my rights and claims for reimbursement under my health insurance policy. I agree to cooperate with STAR and to provide such information as is needed to establish my eligibility for such benefits.

WAIVER AND RELEASE: I hereby release, discharge and acquit STAR Physical Therapy, LLC its agents, representatives, affiliates, employees or assigns of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

NOTICE OF PRIVACY PRACTICES: I acknowledge that a copy of the Notice of Private Practices is posted in the clinic and available for my review. Furthermore, I understand that I can request, and immediately receive, a copy of this document.

Patient / Legal Representative Signature:	Date:

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PHYSICAL THERAPY

Benefit Clarity Document

Patient Name:	DOB:	Account #:

Based upon the benefits verified for you by STAR, either a down payment or co-payment may apply for your visits. Below are details regarding these payment types as well as important information for you to review.

- **DOWN PAYMENT** – Where a deductible remains or a co-insurance applies, STAR collects a down payment per visit towards what will eventually be due once your insurance receives and processes our claims. You will be billed the difference between what you have already paid and what your insurance applies to your responsibility. Down payments are not payments in full for services rendered.

  Example 1: *Mr. Smith had $1,500 remaining on his deductible. He attended 12 visits of therapy where he paid $100 down payment per visit for a total of $1,200.*

  Example 2: *Ms. Johnson's annual deductible was met. Her 20% coinsurance applied. She attended 10 visits of therapy where she paid $22 down payment per visits for a total of $220.*

  In both examples, STAR will bill the patient any remaining insurance amount due. Patients will be billed for the difference between down payments made at each visit and what the insurance determines is the total patient responsibility.

- **CO-PAYMENT** – Where a co-payment applies, STAR collects a fixed amount per visit.

- **NONE** – Based upon verification of benefits made, STAR will not be collecting on a per visit basis. Usually this is the case when a patient has a primary & secondary insurance *(no deductible to be met)* or when a patients max out of pocket has been met. A balance may be due, and will be billed, once insurance has processed all claims.

★ **AFFORDING THERAPY** - Healthcare can be expensive, and we are here to help! Our time of service payment plan allows you to pay a lesser amount per visit with the ability to pay off the balance with monthly payments. No interest. No penalties. No fees. Just help! We want you to be able to afford the care you need!

★ **STAR UNABLE TO GUARANTEE BENEFIT DETAILS** - Insurance does not mandate that healthcare providers verify and communicate benefits to patients. STAR does this as a COURTESY and in an effort to educate our patients on what they might expect. STAR is unable to obtain GUARANTEES regarding the benefits we verify and therefore cannot pass any GUARANTEES along to our patients. Benefits differ from insurance to insurance and plan to plan.

★ **INDEPENDENT VERIFICATION** - We ask that patients contact their insurance company and obtain benefits for therapy services independent of STAR's verification. If anything is found to be different, we ask that you call or alert us immediately at your next visit. The last thing STAR wants is for a patient to be billed for an unexpected amount! We strive to provide BOTH clinical & administrative EXCELLENCE at STAR!

Patient / Legal Representative Signature:	Date: