

## 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 Partnership;

\_\_\_\_\_ 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

**A. PATIENT**

Please Print Legibly

Account #:

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

**B. EMERGENCY CONTACT**

<b>Relationship to Patient:</b> <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Child <input type="checkbox"/> Grandparent <input type="checkbox"/> Sibling <input type="checkbox"/> Friend <input type="checkbox"/> Other:		
<b>First Name:</b>	<b>Middle Initial:</b>	<b>Last Name:</b>
<b>Home Phone:</b>	<b>Work Phone:</b>	<b>Cell Phone:</b>
<b>Preferred Contact Method:</b> <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Cell Phone		

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

<b>Relationship to Patient:</b> <input type="checkbox"/> Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other:		
<b>First Name:</b>	<b>Middle Initial:</b>	<b>Last Name:</b>
<b>Home Phone:</b>	<b>Work Phone:</b>	<b>Cell Phone:</b>

**D. ACCIDENT**

<b>Was your injury as a result of a Work Related or Auto Accident?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, <input type="checkbox"/> Work <input type="checkbox"/> Auto		
<b>Work Comp or Auto Insurance Name:</b>		
<b>Phone #:</b>	<b>Policy #:</b>	<b>Claim #:</b>
<b>Adjuster Name:</b>	<b>Accident Date:</b>	<b>Accident State:</b>

**E. INSURANCE** (if applicable)

<b>Primary Insurance:</b> (copy of card must be on file) <b>Check here</b> <input type="checkbox"/> if Name, SSN & DOB same as patient.	
<b>Insurance Name:</b>	
<b>Subscriber (Insured) Name:</b>	
<b>Relationship of Patient to Subscriber:</b> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
<b>SSN #:</b>	<b>DOB (mm/dd/yy)</b>
<b>Secondary Insurance:</b> (copy of card must be on file) <b>Check here</b> <input type="checkbox"/> if Name, SSN & DOB same as patient.	
<b>Insurance Name:</b>	
<b>Subscriber (Insured) Name:</b>	
<b>Relationship of Patient to Subscriber:</b> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other	
<b>SSN #:</b>	<b>DOB: (mm/dd/yy)</b>

<b>Patient Name:</b> _____	<b>DOB:</b> _____	<b>Account #:</b> _____
----------------------------	-------------------	-------------------------

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)*

<input type="checkbox"/> Sitting	<input type="checkbox"/> Lifting	<input type="checkbox"/> Use of Computer	<input type="checkbox"/> Bending
<input type="checkbox"/> Standing	<input type="checkbox"/> Walking	<input type="checkbox"/> Driving	<input type="checkbox"/> 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:**

<input type="checkbox"/> Medical Doctor (MD)	<input type="checkbox"/> Physical Therapist	<input type="checkbox"/> Speech Therapist	<input type="checkbox"/> Osteopath (DO)
<input type="checkbox"/> Chiropractor	<input type="checkbox"/> Dentist	<input type="checkbox"/> Psychiatrist	<input type="checkbox"/> 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)*

<input type="checkbox"/>	asthma	<input type="checkbox"/>	cancer	<input type="checkbox"/>	high blood pressure
<input type="checkbox"/>	mutiple sclerosis	<input type="checkbox"/>	circulation problems	<input type="checkbox"/>	post menopause
<input type="checkbox"/>	diabetes	<input type="checkbox"/>	depression	<input type="checkbox"/>	epilepsy
<input type="checkbox"/>	hepatitis	<input type="checkbox"/>	heart problems	<input type="checkbox"/>	stomach ulcers
<input type="checkbox"/>	stroke	<input type="checkbox"/>	tuberculosis	<input type="checkbox"/>	rheumatoid arthritis
<input type="checkbox"/>	kidney disease	<input type="checkbox"/>	blood clots	<input type="checkbox"/>	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)*

<input type="checkbox"/>	diabetes	<input type="checkbox"/>	cancer	<input type="checkbox"/>	high blood pressure
<input type="checkbox"/>	heart disease	<input type="checkbox"/>	kidney disease	<input type="checkbox"/>	inflammatory arthritis
<input type="checkbox"/>	stroke	<input type="checkbox"/>	depression	<input type="checkbox"/>	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:**

<b>Patient Name:</b>	<b>DOB:</b>	<b>Account #:</b>
----------------------	-------------	-------------------

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

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Anti-inflammatories (Advil/Ibuprofen)	<input type="checkbox"/> Stomach Ulcer Medications
<input type="checkbox"/> Tylenol	<input type="checkbox"/> Vitamin / Mineral Supplements	<input type="checkbox"/> 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.**

<input type="checkbox"/> 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 on 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

Feeling of **unsteadiness** when standing or walking?  Yes  No

Worries about **falling**?  Yes  No

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

<input type="checkbox"/> Headaches	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Nausea	<input type="checkbox"/> Ear Ringing	<input type="checkbox"/> 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 **current 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*)?

<input type="checkbox"/> Accident - Work Related	<input type="checkbox"/> Bending	<input type="checkbox"/> Reaching	<input type="checkbox"/> Lifting
<input type="checkbox"/> Accident - Motor Vehicle	<input type="checkbox"/> Gradual Onset	<input type="checkbox"/> Falling	<input type="checkbox"/> Other
<input type="checkbox"/> Accident - Third Party / Liability	<input type="checkbox"/> No Apparent Reason	<input type="checkbox"/> Dressing	

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

<input type="checkbox"/> Sitting _____ minutes	<input type="checkbox"/> Rising	<input type="checkbox"/> Lying	<input type="checkbox"/> Grooming
<input type="checkbox"/> Standing _____ minutes	<input type="checkbox"/> Turning	<input type="checkbox"/> Dressing	<input type="checkbox"/> Bending
<input type="checkbox"/> Walking _____ feet	<input type="checkbox"/> Driving	<input type="checkbox"/> Reaching	<input type="checkbox"/> Athletics
<input type="checkbox"/> Sleeping _____ hours	<input type="checkbox"/> Stairs	<input type="checkbox"/> Housework	<input type="checkbox"/> Other

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

<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Bracing	<input type="checkbox"/> Injection	<input type="checkbox"/> Medication
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Orthotics	<input type="checkbox"/> Myelogram	<input type="checkbox"/> Chiropractic
<input type="checkbox"/> Nerve Conduction Study	<input type="checkbox"/> CT Scan	<input type="checkbox"/> MRI	<input type="checkbox"/> X-Ray

<b>Patient Name:</b>	<b>DOB:</b>	<b>Account #:</b>
----------------------	-------------	-------------------

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

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

<b>Back:</b> 0 1 2 3 4 5 6 7 8 9 10	<b>Arm:</b> 0 1 2 3 4 5 6 7 8 9 10	<b>Leg:</b> 0 1 2 3 4 5 6 7 8 9 10
<b>Neck:</b> 0 1 2 3 4 5 6 7 8 9 10	<b>Hand:</b> 0 1 2 3 4 5 6 7 8 9 10	<b>Foot:</b> 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:

<p><b>KEY</b></p> <p>///// Stabbing</p> <p>xxxxx Burning</p> <p>00000 Pins &amp; Needles</p> <p>_____ Numbness</p>	
--	--

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

<b>Patient / Legal Representative Signature:</b>	<b>Date:</b>
<b>Therapist Signature:</b>	<b>Date:</b>



## Consent & Statement of Financial Responsibility

<b>Patient Name:</b>	<b>DOB:</b>	<b>Account #:</b>
----------------------	-------------	-------------------

**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.

<b>Patient / Legal Representative Signature:</b>	<b>Date:</b>
--	--------------

<b>Patient Name:</b>	<b>DOB:</b>	<b>Account #:</b>
----------------------	-------------	-------------------

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 \$1,700 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% co-insurance applied. She attended 10 visits of therapy where she paid \$22 down-payment per visits for a total of \$220.*

In both examples above, patients will be billed for the difference between down-payments made at each visit and what insurance determines is the total patient responsibility due. **Initial:** \_\_\_\_\_

- 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!

<b>Patient / Legal Representative Signature:</b>	<b>Date:</b>
--	--------------

# TELEHEALTH SERVICES CONSENT FORM

1. I voluntarily wish to engage in a telehealth visit with my physical therapy provider at STAR Physical Therapy, Limited Partnership (hereinafter "PT Provider").
2. My PT Provider has explained to me that HIPAA-compliant video-conferencing technology will be used to enable the telehealth visit. I understand this visit will not be the same as an in-person, direct patient-physical therapy provider visit due to the fact that I will not be in the same room as my PT Provider.
3. I understand there are potential risks associated with using video-conferencing technology, including (a) the risk of technical interruptions or failures, or (b) the risk of unauthorized access to my healthcare information. I understand that either my PT Provider or I may discontinue the telehealth visit if it is felt that the video-conferencing connections are not adequate or secure for the telehealth visit.
4. I hereby hold harmless and agree not to sue PT Provider, and its parent company, subsidiaries, agents, affiliates, associates, officers, directors, owners, and employees (collectively "Releasees") from any losses or damages due to loss of, or unauthorized access to, my health information caused by or alleged to be caused by technical interruptions, failures, or difficulties in connection with the telehealth services provided by Releasees, to the fullest extent permitted by law.
5. I understand that PT Provider may share my health information with other individuals for scheduling and billing purposes. I further understand that other staff members may be present during my telehealth visit to operate the video-conferencing equipment, as needed, and the above-mentioned individuals will maintain confidentiality of the information obtained.
6. I understand that for each telehealth session, I will be asked to show a photo ID to confirm my identity. Likewise, I have the right to ask PT Provider practitioner to show his/her identification and credentials to confirm his/her identity.
7. By signing this form, I certify that:
  - I have read or had this form read and/or had this form explained to me.
  - I fully understand its contents including the risks and benefits of engaging in the telehealth session.
  - I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.
  - I understand my email address will be used for telehealth purposes.

---

**Patient Printed Name**

---

**Email Address**

---

**Date of Birth**

---

**Patient or Parent/Legal Guardian Signature**

---

**Date**