Acct #:

Patient's Name: ______________________ **DOB:** ____________

Section I: Financial Policy

In the interest of good health care practice, it is desirable to establish a policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health, and we wish to spend our time and energy towards that end. Therefore, we wish to clarify the following:

Explanation of Insurance Billing and Coverage:

We will prepare and deliver a medical claim for all costs of your care if you present your current health insurance card during your office visit. This service is not a guarantee that we have a contractual relationship with your insurance plan and cannot guarantee that your specific insurance policy covers the services that we will provide.

- ***Patients who reserve an appointment with Spooner Physical Therapy & Wellness and fail to keep that appointment will be contacted on their 1st and 2nd NO SHOW appointments and then the 3rd appointment will be a SAME DAY SCHEDULE PATIENT ONLY. Please cancel appointments that you will not be able to attend 24 hours prior to the reserved time.***
- We have verified your insurance coverage as a courtesy to you and based on your benefits we will require a payment of $ ______________ ________________ at each visit to be applied towards your final balance.
- We will submit a claim to your insurance carrier as a courtesy to you and bill you directly for any additional co-payment, co-insurance, deductible, non-covered charges, or denied services.
- If your claim is denied due to lack of coverage or your insurance company does not pay for the services rendered, you will be responsible for the entire balance.
- You should hear from your insurance company within 30 days of your treatment. If you do not, or you believe that your insurance company has not paid your claims correctly, you should contact your insurance company to negotiate a solution. We do not have a way to access the terms and conditions of your insurance policy and are therefore unable to speak on your behalf to your insurance company about contract disputes that you have.
- We do not accept litigated claims, third party claims, or letters of protection and will require payment at the time of service.

Explanation of Patient Billing:

- You will receive a statement from us monthly once you have a balance due. Your payment to us is due to us within 10 days of the statement date.
- If not paid according to terms, you understand that our office reports to an outside collection agency. In the event that your account is turned over for collections you agree to pay all additional fees assessed in the collection of the debt. These fees include collection agency fees and attorney fees.

Section II: Signature

________ (INITIAL) I HAVE BEEN INFORMED OF MY PRIVACY RIGHTS, and have been offered the Notice of Privacy Practices by Spooner Physical Therapy & Wellness .

________ (INITIAL) I AUTHORIZE RELEASE OF ANY PERSONAL OR HEALTH INFORMATION to third party payers, government agencies, healthcare providers or any other organizations that may assist Spooner Physical Therapy & Wellness in meeting my healthcare needs and in order to secure payment for services rendered.

________ (INITIAL) I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO Spooner Physical Therapy & Wellness and have read and agree to the above stated financial policies.

________ (INITIAL) I CONSENT TO ANY THERAPY, TREATMENT, OR FACILITY SERVICES rendered under the general and special instructions of the therapist assigned to care for me. I agree and consent to Spooner Physical Therapy & Wellness to furnish care and treatment considered necessary and proper in diagnosis and treatment of my physical condition.

________ (INITIAL) I understand that any photo or video image(s) taken while in the offices of Spooner Physical Therapy & Wellness might be used in print and/or on-line media publication, advertisement, and in any other format that Spooner Physical Therapy chooses.

I have read the above information and by signing below consent to treatment, release of information, assignment of benefits, and acknowledgement of privacy practices and financial responsibility.

Signed:	**Today's Date:**

SPOONER PHYSICAL THERAPY & WELLNESS

Name:____

Date:____

Please check the following conditions as they apply to you:

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Cancer
- ☐ Cardiac Conditions
- ☐ Cardiac Pacemaker
- ☐ Chemical Dependency
- ☐ Circulation Problems
- ☐ Currently Pregnant
- ☐ Depression
- ☐ Diabetes
- ☐ Dizzy Spells
- ☐ Emphysema/Bronchitis
- ☐ Fractures
- ☐ Fibromyalgia
- ☐ Gallbladder Problems
- ☐ Headaches
- ☐ Hearing Impairment
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Incontinence
- ☐ Kidney Problems
- ☐ Metal Implants
- ☐ MRSA
- ☐ Multiple Sclerosis
- ☐ Muscular Disease
- ☐ Osteoporosis
- ☐ Parkinsons
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Smoking
- ☐ Strokes
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Vision Problems
- ☐ Other_________________

1. Are you currently taking any medications? Y / N If **yes**: Is list attached Y/N OR please list below:

Medication____________________Dosage_______________Reason for taking:_______________________________

Medication____________________Dosage_______________Reason for taking:_______________________________

Medication____________________Dosage_______________Reason for taking _______________________________

2. Height___________________**Weight**______________________

3. Have you had any past surgical procedures? Y / N

If yes, please list and include month and year:____

4. Are you currently pregnant? Y / N **Or have you been in the last year?** Y / N

5. Do you smoke? Y / N **Do you drink alcohol?** Y / N

6. Have you received physical therapy previously? Y / N

7. Is this work related? Y / N **Is this related to an auto accident?** Y / N

8. Please describe your injury and location of pain:____

9. How and when did it start?____ ___________________________

10. Does your current problem interfere with any of the following:

- ☐ Reading
- ☐ Combing hair
- ☐ Bending over
- ☐ Climbing stairs
- ☐ Sleeping
- ☐ Walking
- ☐ Lifting a gallon of milk
- ☐ Standing
- ☐ Driving
- ☐ Putting on shoes
- ☐ Reaching overhead
- ☐ Writing a letter
- ☐ Sitting
- ☐ Dressing
- ☐ Other

Please circle your level of pain:

0 1 2 3 4 5 6 7 8 9 10

0 being no pain **10 go to emergency room**

Please mark area of pain

Communication Consent

____ Call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out physical therapy, such as appointment reminders, insurance items and any calls pertaining to my clinical care.

____Mail to my home or other alternative location any items that assist the practice in carrying out physical therapy, such as appointment reminder cards and patient statements.

____E-mail to my home or alternative location any items that assist the practice in carrying out physical therapy, such as appointment reminders, patient statements and correspondence.

____(E-mail address)

____Text messaging consents to send appointment reminders to my cellular device via text messaging. Spooner Physical Therapy and Rehab Specialists are not responsible for any carrier charges that may apply to this form of communication. Phone number:____

By signing this form, I am consenting to allow Spooner Physical Therapy and Rehab Specialists to use and disclose my personal health information to carry out physical therapy.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Spooner Physical Therapy and Rehab Specialists may decline to provide treatment to me.

Signed by:_________________________________Date:_____________________________

Print Patients name:____

Print Name of Legal Guardian, if applicable____

Designation for release of Medical Information to a Family Member, Friend, or Legal Representative.

It is a clinical staff's responsibility to ensure that the provider-patient relationship is confidential. The Health Portability and Accountability Act (HIPAA) allows providers to use their professional judgment on disclosing certain personal health information to family, friends, etc without an authorization. This form is an aid to the clinical staff in making a determination on disclosing such information. Spooner Physical Therapy & Wellness realizes that there are times when you, the patient, may want another person to be knowledgeable about your condition, needs or treatment plans including appointment times and account status. We want you to be able, if you so desire, to name a person to whom you want the office staff able to speak with about your treatment, visits or other pertinent information. To enable that, we would ask that you complete the form listed below. Please note the following points prior to signing:

- Only one person can be designated for this role.
- The designation is valid until you cancel it in writing
- If you designate no Spooner Physical Therapy & Wellness will not release information to any family member, friend or legal representative.

Designation Statement

I, ____, designate the following person to be able to speak to my provider at Spooner PT&W, or other staff members, should it be necessary, on my behalf. I hereby give permission to Spooner PT & W, though its clinical providers and staff to release to my designee any information about my medical condition or treatment or the status of my account and I release Spooner PT &W its providers and staff, from status of my account and I release Spooner PT & W its providers and staff, from any claim of confidentiality in connection with the release of this information.

Name of Designated Person: ____

Relationship: ___________________________Phone Number: ____________________

Patient's Sigature: ____

Date: ________________________________ Witness: __________________________

I Decline to designate another person to speak with my provider or clinical staff:

Patient's Sigature: ____

Date: _________________Witness: ______________________________________