HANDLING
PHYSICAL THERAPY

WELCOME TO HANDLING PHYSICAL THERAPY

We are glad that you are here and will do everything we can to help you. We are staffed with qualified personnel to design and direct your rehabilitation program so that you can return to your optimal level of function as soon as possible.

The initial evaluation will take approximately one hour

Please bring: prescription for physical therapy from your physician
Insurance Information
Loose, comfortable clothing
Insurance referral form (if necessary)
Applicable splints or braces that you may be wearing

Follow up appointments will be approximately one hour long. Please schedule your appointments at the front desk following your initial evaluation. Your frequency of visits may later be modified depending on the physician, the therapist, the insurance parameters and the progress made with therapy.

Please call and cancel your appointments if for any reason you are not able to come. Failure to do so could result in a charge for the missed visit.

Children accompanying parents to therapy must remain in the waiting room and must have adult supervision. This will help ensure the safety of the children.

Billing questions should be directed to our billing department at (302) 633-5840. We submit claims on a bi/weekly basis and a billing statement will automatically be generated when an insurance carrier has processed the claim. The patient is responsible for any balance not paid by his/her primary and/or secondary insurance company.

Due to new healthcare regulations and in order to serve you properly, ALL of the following information MUST be completed. All information will be kept confidential. PLEASE PRINT

Thank you for choosing our office! Please do not hesitate to ask us any questions. If at any time a procedure or an exercise causes you increased pain or discomfort, let us know! We will do our best to help you improve as much as possible.

HANDLING PHYSICAL THERAPY

PATIENT INFORMATION

NAME: _____ DOB: _____ AGE: _____

ADDRESS: _____ CITY: _____ STATE_____ ZIP: _____

EMAIL ADDRESS: _____

HOME #: _____ CELL #: _____ WORK #: _____ EXT: _____

Preferred Language if not English: _____

MARITAL STATUS: Single Married Divorced Widow GENDER: Male Female Other

EMPLOYER: _____ ATTORNEY: _____ PHONE: _____

EMERGENCY CONTACT: _____ RELATION: _____ PHONE #: _____

May we speak with this person regarding your medical history/PT schedule? Yes or No

RESPONSIBLE PARTY

(Complete if patient is a minor and/or policy holder is someone other than yourself)

NAME: _____ DOB: _____ AGE: _____

RELATION TO PATIENT: Self Spouse Parent Other

ADDRESS: _____ CITY: _____ STATE_____ ZIP: _____

HOME PHONE #: _____ CELL #: _____ WORK #: _____

CONSENT

Authorization to Pay Insurance Benefits

I hereby authorize payment directly to *Handling Physical Therapy, LLC* for all benefits payable to me under the terms of my insurance policy with respect to service provided for myself or my dependents.

I understand that I am financially responsible for any balance of charges not covered by my insurance including deductibles and/or co-payments and any collection agency fees if necessary.

Authorization to Release Medical Information

I authorize *Handling Physical Therapy, LLC* to release any medical information necessary to process insurance claims and/or coordinate my care.

Consent For Treatment

I give consent to *Handling Physical Therapy, LLC*, its staff and related associates to provide outpatient physical therapy services considered necessary and proper for my diagnosis. I accept that treatment does not guarantee improvement and may, at times, exacerbate symptoms.

Patient understands that it is his or her responsibility to schedule appropriate follow-up appointments with their referring physician according to his/her insurance guidelines. Frequent cancellations or no-shows may result in a $30 fee and/or discontinuation of therapy.

No audio or video recording is permitted at any time.

SIGNATURE: _____ DATE: _____

(Signature must be parent / guardian if patient is under 18 years of age)

HANDLING PHYSICAL THERAPY

PATIENT MEDICAL HISTORY FORM

NAME: _____ DOB: _____ AGE: _____

Occupation: _____

Type of Work Involved: _____

Do you have any of the following?

High Blood Pressure	YES	NO	HIV/AIDS	YES	NO
Heart Condition	YES	NO	Cancer	YES	NO
Stroke	YES	NO	Seizures	YES	NO
Diabetes	YES	NO	Back/Neck Injury	YES	NO
Pacemaker	YES	NO	Other Joint Injury: _____		
			Other: _____		

Have you had Home Health Care for this injury/illness? YES NO

If yes, date of discharge from Home Health Care? _____

Is this injury / illness work-related? YES NO

What is the approximate date when this injury occurred or illness began? _____

When is your follow-up with your doctor? _____

Have you had any surgeries in the past five years YES NO

Please List: _____

Have you had previous physical therapy? YES NO

Are you taking any medications? YES NO

Please List: _____

What types of activities would you like to return to?

Please List: _____

How did you hear about us? _____

What is the name of your referring doctor? _____

What is the name of your family / primary care doctor? _____

Signature: _____ Date: _____

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Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ **Date** _____

1. Describe your symptoms _____

_____

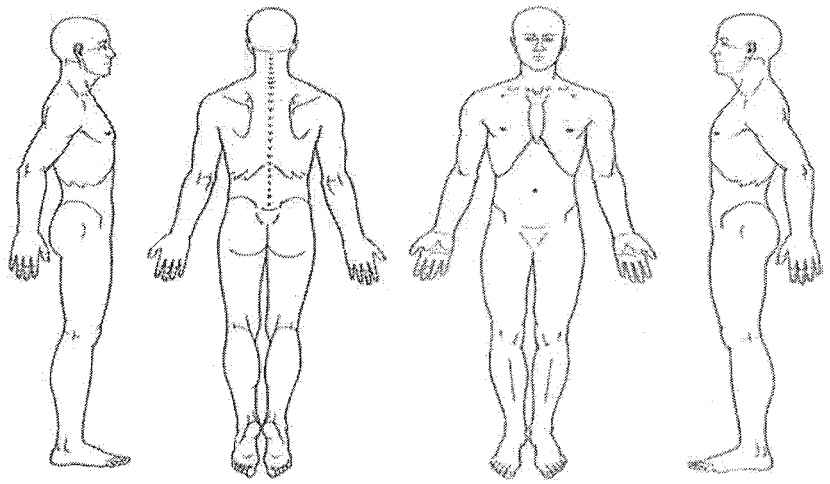
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

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8. Who have you seen for your symptoms?

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

_____

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ **Date** _____

HANDLING PHYSICAL THERAPY

STATEMENT OF INSURANCE BENEFITS

We have verified your benefits with your health insurance company _____. According to this information, your insurance ESTIMATES that it will pay _____. Co-insurance will be billed to the patient upon receipt of insurance payment/explanation of benefits. **Co-pays are due at the time of your visit. Your co-pay is _____.**
Additional comments _____

Handling Physical Therapy advises that you also verify your insurance benefits. The benefits stated are not a guarantee of payment final determination is made at the time the claims are received by the insurance company.

The following is a summary of our billing procedures at Handling Physical Therapy. As a client, it is ultimately your responsibility for paying your medical cost. As a courtesy to you, we are available to help with any questions you may have. All clients are responsible for securing and maintaining an updated prescription from the ordering physician.

If you are a Medicare patient, your prescription is good for thirty (30) days from the date on your prescription regardless of how long the doctor has prescribed treatment. If therapy is still needed at the end of 30 days, you will need to get an updated prescription from the physician, or Medicare will not cover the cost. Medicare will not cover the cost for therapy where progress has plateaued or the client has reached functional levels. We will help monitor your progress to avoid a Medicare denial.

If any insurance payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to Handling Physical Therapy. We do not bill your third party insurance. Statements are available for patient resubmission request.

If you have a Workman's Comp claim or a Motor Vehicle Accident claim, you are responsible for filling a claim with the employer or automobile insurance company prior to physical therapy. You need to provide our office with the following information.

1. Name, address and phone number of the carrier to be billed.
2. Claim number
3. Date of injury/accident
4. Name and phone number of adjuster/contact person.

Please be advised if you claim Worker's Comp/MVA benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you. Please present any medical insurance at your first visit. Denied WC/MVA claims will be billed to medical insurance providers with whom we participate.

We submit claims on a biweekly basis and a client statement will automatically be generated when the insurance carrier has processed the claim. You are responsible for any balance due. I understand and agree that if I fail to make any of the payment for which I am responsible in a timely manner, I will be responsible for all cost of collecting monies owed, including court cost, collection agency fees and attorney fees. You may contact our billing office at (302) 633-5840 with any questions.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT

_____ _____
PATIENT/GUARDIAN/RESPONSIBLE PARTY **DATE**

_____ _____
HANDLING PHYSICAL THERAPY REP/WITNESS **DATE**

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Notice of Privacy Practices

In accordance with HIPAA privacy regulations, we are notifying you as to how medical/protected information about you may be used and disclosed. This is a summary of our comprehensive notice, of which you may request a copy at the front desk. For your convenience it is also posted in our office and on our website. Under the law, we are required to maintain the privacy of this information, but may need to share protected health information, (PHI), with others in order to process your claim or for health care operations, which may include but are not limited to:

1. Receive payment
2. Verify insurance
3. Conduct quality assessment
4. Care coordination/management
5. Manage our business
6. Assist other covered entities with their health or business operations
7. Accreditation, certification, licensing, or credentialing
8. Disclosure to the Secretary of the US Department of Health and Social Services
9. Health oversight agencies
10. To prevent a serious threat to health or safety
11. Research
12. Workman's compensation
13. Public health and safety
14. Legal, national security or law enforcement
15. Personal physician, team physician, athletic director, or coach
16. To you or your designee upon your written request, or
17. Other uses and disclosures of PHI only after your written authorization

All evaluation and progress notes, as well as significant changes in medical conditions will be reported via fax, phone, email and/or mail to your referring physician and possibly primary care physician. All insurances will be verified, with pertinent PHI being released to the insurance company(s) necessary to process claims. All patients will be asked to sign in at the front desk upon arrival. Part of treatment is performed in an open environment. Some claims are billed electronically. If you wish not to sign in on the sheet, not to have claims sent electronically, or not to be in an open area for treatment, please notify the receptionist immediately and we will attempt to make alterations to fit your needs. If you have any questions, please ask to speak to our Clinical Director.

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____	_____	_____
Patient Name or Legal Guardian (print)	Signature	Date

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices:

Date: _____ Attempt: _____

Staff Name: _____

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HANDLING
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Client Name: _____ _____
Last First

Home #: _____ **Cell #:** _____ **Work #:** _____

WEEK	DAY	DATE	TIME
1	Monday	_____	_____
	Tuesday	_____	_____
	Wednesday	_____	_____
	Thursday	_____	_____
	Friday	_____	_____
	Saturday	_____	_____

WEEK	DAY	DATE	TIME
2	Monday	_____	_____
	Tuesday	_____	_____
	Wednesday	_____	_____
	Thursday	_____	_____
	Friday	_____	_____
	Saturday	_____	_____

WEEK	DAY	DATE	TIME
3	Monday	_____	_____
	Tuesday	_____	_____
	Wednesday	_____	_____
	Thursday	_____	_____
	Friday	_____	_____
	Saturday	_____	_____

WEEK	DAY	DATE	TIME
4	Monday	_____	_____
	Tuesday	_____	_____
	Wednesday	_____	_____
	Thursday	_____	_____
	Friday	_____	_____
	Saturday	_____	_____

Continuity of therapy sessions is essential for quality rehabilitation. Missing therapy sessions not only hinders your recovery but is costly to your provider. For these reasons, a client who fails to **give 24 hour notice to cancel a scheduled therapy appointment may be charged a $30 fee for the missed visit**. This fee is not covered by your insurance company and payment is required before continuing your therapy sessions. Frequent cancellations or no-shows may result in discontinuation of therapy.

Signature: _____ Date: _____

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