New Patient Information

Referred by:	Today's date:	
Patient Name: (Last) (First) (Middle)		
Home Address:		
City State ZIP		
Home Phone:	Mobile Phone:	E-mail:
I would like to receive appointment reminders via: _____ Email _____ Voicemail _____Text Message		
Sex: **M** **F**	Birthdate:	Social Security #
Referring Physician's Name:	Referring Physician's Phone #:	
If patient is a minor, name of parent or guardian:	Phone # of parent/guardian:	
In case of emergency, please notify: (Last Name) (First Name)		
Phone #:	Relationship to patient:	
Is your condition due to an accident? Y N Date of accident/injury: Type of accident (circle one): Auto Work Home If other, please specify:		
Primary Insurance:	Member ID#	Group#
Name and Date of Birth of Primary Insured:	Relationship to patient:	

Patient/Guardian Signature: _____ Date: _____

Notice of Privacy Practices: Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received **Mile High Physical Therapy's Notice of Privacy Practices** written in plain language. This notice provides in detail the uses and disclosures of my protected health information which may be made by this practice, my individual rights and the practice's legal duties with respect to the protected health information (PHI). This Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted by law for each of the following purposes: treatment, payment and health care operations.
- A description of each of the other purposes which this practice is permitted or required to use or disclose PHI without my written consent or authorization.
- My individual rights with regard to PHI and a brief description of how I may exercise these rights in relation to:
    - The right to complain to the practice and the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory action will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my PHI.
    - The right to receive confidential communication of PHI.
    - The right to inspect and copy PHI.
    - The right to amend PHI.
    - The right to receive and accounting of disclosures of PHI.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all health information that it maintains. I understand that I can obtain the practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____

FINANCIAL POLICY AND AGREEMENT

Thank you for choosing **Mile High Physical Therapy** to provide your professional physical therapy services. We are committed to providing you with the best possible care. We need your assistance and your understanding of our payment policies. If you have any questions about or policies, or if we can be of further assistance, please do not hesitate to ask.

We are happy to cooperate with patients who are covered by insurance and/or Medicare. Please remember that your insurance is a contract between you and your insurance company, and we do not know the limitations of your coverage. **We ask that you read your insurance policy and/or call your insurance company or insurance broker to be sure that you are fully aware of any limitations of the benefits provided.**

1. It is the policy of Mile High Physical Therapy that payment is due at the time of service unless other financial arrangements are made in advance. **We require all patients to pay their deductible, co-pay and/or coinsurance at the beginning of each visit.** At the conclusion of your therapy with Mile High Physical Therapy, you may be billed for any outstanding balances. If there is a positive balance or credit, you will be provided with a refund promptly.
2. While the filing of insurance claims is a courtesy that we extend to our patients, **we must emphasize** that, as professional healthcare providers, our relationship is with you, the patient, and not your insurance company. If we do not receive reimbursement from your insurance company within 30 days, full payment of the account balance becomes your responsibility and will accrue a finance charge of 1.5 % of the average daily balance (18% annually).
3. We accept Medicare assignment, and therefore we agree to accept payment for your services directly from Medicare. We cannot charge you for any amounts in excess of the amount approved by Medicare for your service. However, you are still responsible for your **co-payment** and **estimated portion of the fees** at the time of your appointment.
4. You authorize us to release all records and information necessary to file claims with your insurance provider(s) and/or Medicare. You certify that the information you provide to us in order to file such claims is correct.
5. We currently accept cash, check, or credit. We do not accept liens against litigation proceeds.
6. Your appointment time is reserved just for you because you are important to us. **You may be charged a fee if you do not show up for a scheduled appointment.** If you need to cancel and/or re-schedule your appointment, please see our cancellation and no-show policy.
7. All returned checks are subject to additional collection fees.

Unless I have paid at the time of treatment, I hereby authorize direct payment of benefits from my insurance provider(s) and/or Medicare to **Mile High Physical Therapy** for services rendered. I understand that I am financially responsible for any balance not covered by the insurance provider(s) and/or Medicare. I also understand that **Mile High Physical Therapy** is not required to wait for insurance reimbursements where coverage is uncertain or denied.

I also assign to **Mile High Physical Therapy** all my rights and remedies to recover payment of insurance benefits due under my insurance policy, including, but not limited to, my rights to bring suit against the insurance company and seek judgment against the insurance company for any and all unpaid medical and rehabilitation benefits for services rendered to me by or at the direction of **Mile High Physical Therapy**. I further assign my rights to recover attorney fees and costs incurred by **Mile High Physical** in recovering payment of benefits.

I HAVE READ AND UNDERSTAND THIS ENTIRE AGREEMENT AND I HAVE NOT SIGNED BELOW IN RELIANCE UPON ANY VERBAL OR WRITTEN PROMISE, CONDITION, OR REPRESENTATION MADE BY ANY PERSON.

Signature: _____ Date: _____

Patient name: _____

Important Company Policies for a Successful Relationship

Directions: Please read the following guidelines carefully, initial each box, and indicate your agreement by signing at the bottom of the page.

☐ **"No Shows" Are Bad**
$70.00 Fee
We care about our patient's care, when you do not show for an appointment you are not only affecting your own care but the possible care of another patient. If you "no show" for more than two appointments, we will be unable to schedule future appointments for you unless you see your physician.

☐ **24-Hour Advance Notice for Cancelations**
$70.00 Fee
We ask that you provide a 24-hour notice if canceling an appointment. This gives us ample time to schedule and provide care to another patient.

☐ **Late Policy "10 Minutes"**
Being late by more than 10 minutes will require you to either reschedule your appointment or wait for the next available appointment.

☐ **Payment Due at Time of Service**
We accept personal checks, cash or credit.

☐ **Important Notice from the Federal Government**
"It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments... even if your doctor allows it. Unless you complete a 'Financial Hardship' form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. Both parties may be charged for breaking the law. This includes services deemed as 'professional courtesy' and 'TWIP's- Take What Insurance Pays'. Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, and State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A(a) (5) of the Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA]. Exceptional cases do not apply. For questions please contact: Office of Inspector General, Department of Health and Human Services. Contact by phone: 202-619-1343, by fax: 202-260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building, 333 Independence Avenue, S.W.' Washington, D.C. 20201, Joel Schaer, Office of Counsel to the Inspector General, 202-619-0089."

☐ **Patient Consent to Treatment**
I request rehabilitation services from Mile High Physical Therapy and consent to the treatment ordered by my physician who directs and monitors my care. Mile High Physical Therapy is not liable for any act or omission when following the instructions of my physician. I hereby consent to the release of information and my clinical records to Mile High Physical Therapy by any health care provider, including my physician, hospital, skilled nursing facility, home health agency, or rehabilitation agency, where I have been a patient and to disclose all or any part of my clinical records to Mile High Physical Therapy.

Patient Name: _____

Patient Signature: _____ Date: _____

PATIENT HISTORY

Patient Name:	Date of Birth:

Please place an "X" next to any of the following which you currently have or have had in the past:

_____Circulatory Disorder _____ Heart Disease _____ Heart Attack
_____ Surgery _____ Sensitivity to Heat _____ Sensitivity to Cold
_____ High Blood Pressure _____ Hernia _____ Allergies

If you marked an "X" next to any of the above, please explain and give appropriate dates

_____

_____

Are you presently taking any medication on a regular basis? _____ Yes _____ No

If yes, please list them with **dosage**, **frequency** and explain for what reason:

_____

_____

_____

Mark an "X" next to any of the following with which you need assistance:

_____ Transportation _____ Meals _____ Domestic Chores
_____ Shopping/Errands _____ Personal Care _____ Other

Mark an "X" next to any of the following which your injury/disability has caused:

_____ Financial Problems _____Family Problems _____Emotional Problems _____Other

Please explain: _____

_____

How did your injury occur? _____

_____

What form of treatment have you previously received? _____

_____

Are you prevented from anything you used to do? _____

_____

What are you goals for treatment? _____

_____

Patient Signature: _____ Date: _____