ADVANTAGE
PHYSICAL THERAPY & WELLNESS P.C.

Patient Information

Patient Name: _____ Age: _____
Last First Middle

Name you wish to be called: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____Work Phone #: _____Cell Phone #:_____Marital Status: _____

Would you like Appointment Reminders? ☐ Yes ☐ No

If yes, would you prefer: ☐ Voice Call ☐ Email Email Address: _____
☐ Text Message Cell Phone #_____

Patient's Social Security #: _____ Sex: _____ Date of Birth: _____

Patient's Employer: _____ Address: _____

Name of Spouse: _____ SS#_____ Date of Birth: _____

Referring Doctor: _____ Phone: _____ Next Dr. Appt: _____

Last Dr. Appt: _____ Primary Care Doctor: _____

How did you hear about us?
☐ Radio ☐ Post Card ☐ Buzztown ☐ Facebook ☐ Friend/Family _____
☐ Doctor/Practitioner ☐ Phone Book-Circle one please (Redbook/ Dex) ☐ Other _____

Person to notify in case of emergency:

Name: _____ Home phone: _____ Work phone: _____

Address: _____
Street City State Zip

Responsibility Information

Who will be primarily responsible for the bill? _____

I will be paying my share of financial responsibility by: Cash _____ Check _____ Credit Card _____

PRIMARY Insurance Company: _____ Phone: _____

Policy Holder's Name: _____
Last First Middle

Policy Holder's Social Security #: _____ Date of Birth: _____

Is there secondary insurance? Yes _____ No_____

Name of Secondary Insurance Company: _____

Current Complaint:_____ **Date of Injury or Onset:** _____

Is your current condition related to:

□ WORKER'S COMP □ AUTO ACCIDENT □ OTHER ACCIDENT □ N/A

Please check if you have, or have had any of the following:

Yes	No		Yes	No	
□	□	Allergies	□	□	Dizziness
□	□	Chest Pain	□	□	Headache
□	□	Heart Attack	□	□	Back/Neck Pain
□	□	Pacemaker	□	□	Numbness/Tingling
□	□	Diabetes	□	□	Osteoporosis
□	□	Seizures	□	□	Lung Disease
□	□	Stroke	□	□	Tuberculosis
□	□	Arthritis	□	□	Use of Tobacco
□	□	Cancer	□	□	HIV+/Aids
□	□	Asthma	□	□	Hepatitis
□	□	Major Illness/Accident	□	□	Epilepsy
□	□	Reaction to chemicals	□	□	Joint Replacement/Pins
□	□	Broken Bones	□	□	Bladder Trouble
□	□	Possibly Pregnant	□	□	Wear Orthotics

Please list any medication you are currently taking: _____

_____

Have you ever been hospitalized or had surgery? □ Yes □ No If yes, when and for what? _____

_____

Have you ever participated in a physical therapy program before? □ Yes □ No If yes, for what condition?

_____

Please share any other information which may be useful to your therapist to assist in your care.

_____

Patient Release & Information:

I, the undersigned, hereby request evaluation and treatment by Advantage Physical Therapy and consent to care and treatment as ordered by my physician(s). I authorize the release of information related to my rehabilitation to my physician(s).

Printed Name: _____

Signed: _____ Date: _____

If patient is less than 18 years of age:

Parent or Legal Guardian Name: _____ Social Security #: _____

I hereby grant Advantage Physical Therapy & Wellness, PC the authorization to render the services of physical therapy to my minor child.

Signature authorizing treatment of minor child: _____ Date: _____

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MISSED APPOINTMENT POLICY- Effective 1/1/14

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well being and gain of your physical abilities is something every one in our clinic takes quite seriously.

Because we care so much about you we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep all your appointments. Write down the time of your visits so that you do not forget.

With the exception of serious emergencies it is expected that you keep all your appointments. If you need to re-schedule an appointment we require a **24 hour notice**. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferably the very next day.

In an instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a **$40.00 fee**.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to place you on same-day scheduling or discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

Mike Testa, MSPT, CSCS and Amy Testa, MSPT
Advantage Physical Therapy & Wellness, P.C.

I have read and understand this policy:

Name:_____ Date:_____

FINANCIAL AGREEMENT- Effective 1/1/14

Thank you for choosing Advantage Physical Therapy & Wellness, P.C. for your physical therapy needs. We are committed to your treatment being successful. Please understand that payment of your bills is considered part of your treatment. We will require that you read and sign this agreement before beginning any treatment. PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, AND MOST CREDIT CARDS.

Missed Appointments: As every effort is made to be on time for our patients, we ask that you extend the same courtesy to us by arriving a few minutes before your scheduled appointment. **Unless cancelled at least 24 hrs. in advance, our policy is to charge for missed appointments at the rate of $40.00. This charge is not covered by your insurance company and will be billed directly to you.**

Regarding Insurance: If we are a *participating provider* with your insurance company, we will collect your co-pay and payment for any non-covered supplies at the time of service.
It is your responsibility to make sure your insurance company pays within their contracted period (45 days from date of receipt). To expedite the processing of your claims, please provide our office with your most up to date insurance information. Please contact us immediately if your insurance coverage changes. Patients (except for minors) are responsible for payment. No insurance company attempts to cover all medical costs. Some pay fixed allowances for certain procedures; others pay a percentage of the charge.

- **Assignment of benefits:** In the event that we are a participating provider with your insurance company, we will accept payment from your insurance company. Your signature below authorizes this action; you will be billed for any patient responsibility once your insurance has responded.
- **Self-Pay:** If you do not have any type of insurance, we ask for full payment at the time of service which will be reduced by 15% as a courtesy to you.
- **Medicare:** Our office is a participating provider with Medicare. However, we do require you to pay for any non covered supplies at the time of service.
- **Secondary/Supplemental Insurances:** As a courtesy to our patients, our office will submit your bill to your secondary insurance company. However, we are not responsible for follow up with your secondary insurance company. Any charges allowed by Medicare but not paid by your secondary insurance are your responsibility.

We welcome your questions regarding our insurance billing practices and policy. Please contact our insurance coordinator. We will be happy to help you receive the maximum benefits available under your policy. **Please remember, however, that your medical insurance is a contract between you or your employer and the insurance company. If you insurance does not pay for your visit within 45 days of receipt, we will bill you for the full amount and you may contact your insurance company to reimburse you for their portion of the charges.**

Usual & Customary Rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.

Collection of an Outstanding Balance: PAYMENT IS DUE AT THE TIME OF SERVICE OR WITHIN 30 DAYS OF BEING BILLED! A finance charge of 12% per year will be applied on all accounts that are 30 days past due. If your account should become 90 days past due, and every reasonable attempt has been made on our part to collect the debt, your account may be sent to a collection agency. Reasonable collection costs will be added to your account. You may also be responsible for legal and attorney's fees.

Release of Information: Please refer to the "Health Information Privacy Notice".
I have read the Financial Agreement above and understand and agree to these arrangements.

_____	_____	_____
Printed Patient Name	**Signature of Responsible Party**	**Date**

Thank you for your cooperation and we appreciate you choosing our practice!

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I, _____, have received a Notice of Advantage Physical Therapy & Wellness, PC's privacy practices.

_____ _____
Signature Date

_____ Patient has refused to take the notice.
_____ Patient has refused to sign affirmation of receiving the Privacy notice.

I have given "good faith" effort to either give this patient Notice of Privacy Practices or to get affirmation from the patient, but he/she has refused my attempts.

_____Post: _____Date: _____
Signature

3600 Main Avenue, Suite A | Durango, CO 81301 | Ph: 970.259.7829 Fax: 970.259.9411