



Patient Name: _____ DOB: _____

PATIENT INFORMATION *Please give Rx & Insurance Card to staff for scanning and bring payment with you.

Name _____
First MI Last Nickname

Gender Male Female Other

Date of Birth _____ Last 4 Social Security Number _____

Marital Status Single Married Other

Primary Phone _____ is this your Cell Home Work Can we leave a message?

Secondary Phone _____ Cell Home Work Can we leave a message?

Email _____
For Focus PT survey, reminders and e-newsletters only

Street Address _____

City _____ State _____ Zip _____

Appointment reminder method? Voicemail Text Email

Occupation _____ Are you Working full time Working part time Not working Retired

Employer _____ Work phone # _____

Emergency Contact _____ Relationship (spouse, parent, friend etc.) _____

Emergency Contact Phone # _____

PARENT/GUARDIAN or OTHER INSURED INFORMATION *Please give insurance card to staff for scanning.

Name _____
First MI Last Nickname

Gender Male Female Other

Date of Birth _____ Last 4 Social Security Number _____

Marital Status Single Married Other

Primary Phone _____ is this your Cell Home Work Can we leave a message?

Secondary Phone _____ Cell Home Work Can we leave a message?

Email _____
For Focus PT reminders and e-newsletters only

Street Address (if different from above) _____

City _____ State _____ Zip _____

Occupation _____

Are you Working full time Working part time Not working Retired

Employer _____ Work phone # _____

Phone # (if different from above) _____

Relationship to Patient (spouse, mother, father, friend etc.) _____

REFERRAL INFORMATION

How did you choose Focus Physical Therapy? (check all that apply)

<input type="checkbox"/> A good past experience at Focus	<input type="checkbox"/> Another wellness provider recommended Focus
<input type="checkbox"/> A family member or friend recommendation Who: _____	<input type="checkbox"/> I saw Focus Physical Therapy at an event Event name: _____
<input type="checkbox"/> My doctor recommended Focus	<input type="checkbox"/> I found Focus Physical Therapy on the internet
<input type="checkbox"/> Through our facility partner Recharge Sports	<input type="checkbox"/> Through media (Facebook, YouTube, Advertising)
<input type="checkbox"/> Clinic location is convenient for me	

Referring Doctor's name: _____

When is your next scheduled doctor's appointment? _____

Did you request your therapist by name? Yes No If yes, which therapist? _____

Patient Name: _____ DOB: _____

MEDICAL HISTORY

Height _____ Weight _____ Age _____ Have you fallen in the last year, with or without injury? Yes No
 Do you have a pacemaker? Yes No Are you pregnant (or suspected)? Yes No How many weeks? ____
 How active are you? Very Moderately Slightly Not at all
 Typical Daily Activities (exercise, hobbies etc.) _____

HEALTH SCREENING

In the past 6 months, have you experienced:

<input type="checkbox"/> Difficulty with your bowel or bladder control	<input type="checkbox"/> Unexplained weight change (gain OR loss)
<input type="checkbox"/> Numbness in the genital or anal area	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Unexplained weakness or numbness
<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Frequent falls
<input type="checkbox"/> Fainting or dizziness	<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Calf pain with exercise	<input type="checkbox"/> A wound that does not heal
<input type="checkbox"/> Pain at night or difficulty sleeping	

HEALTH HISTORY

Check if you have had problems with, or been treated for:

<input type="checkbox"/> Cancer What kind? _____	<input type="checkbox"/> Tremors
<input type="checkbox"/> Heart problems (pain, pressure, irregular beats etc)	<input type="checkbox"/> Epilepsy, seizures, convulsions
<input type="checkbox"/> High blood pressure/hypertension	<input type="checkbox"/> Jaw pain or problems (locking, clicking etc.)
<input type="checkbox"/> Broken bones	<input type="checkbox"/> Stomach pains or ulcers
<input type="checkbox"/> Stroke Date? _____	<input type="checkbox"/> Hernias
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Headaches <input type="checkbox"/> Migraine <input type="checkbox"/> Cluster <input type="checkbox"/> Other
<input type="checkbox"/> Liver disease	<input type="checkbox"/> Pain with coughing or sneezing
<input type="checkbox"/> Lung disease or other breathing problems	<input type="checkbox"/> Swollen ankles or legs
<input type="checkbox"/> Diabetes <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2	<input type="checkbox"/> Any infectious disease (TB, HIV, Hepatitis, etc.)
<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Anxiety, depression, panic or other disorder
<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/> Chemical dependency or alcoholism
<input type="checkbox"/> Recent car or other accident or trauma	<input type="checkbox"/> Allergies To: _____
<input type="checkbox"/> Head trauma or concussion	<input type="checkbox"/> Neurologic disease (Parkinson's, MS etc.)
	<input type="checkbox"/> Other _____

Please list any surgeries or hospitalizations:

Date	Surgery/Hospitalization	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

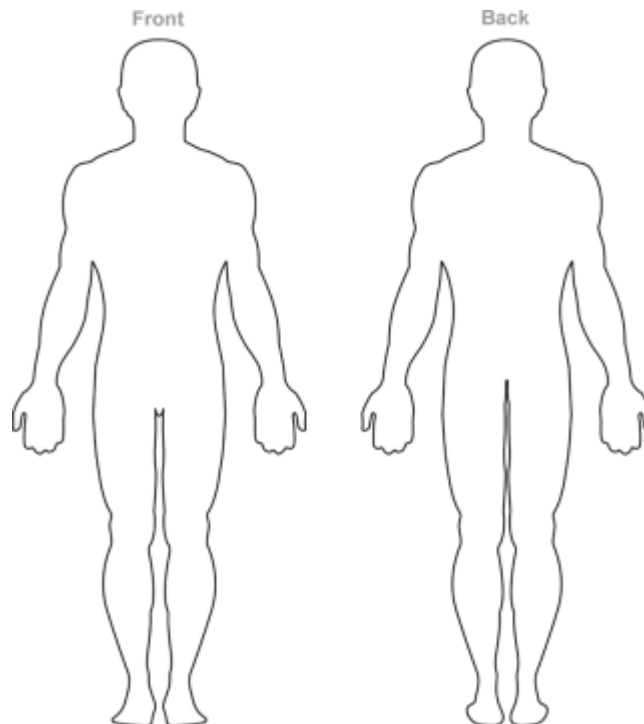
Medications and Supplements (ok to use a separate list):

Name of Medication	How often, your dosage and how you take it?	What is it for?	Prescribing MD
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

CURRENT PROBLEM

What can we help you with today? _____
 How did this problem start? _____
 When did this problem start? _____
 When/how often does this problem occur? (i.e. is it constant; in the am/pm; with certain positions, movements etc.) _____
 What makes this problem feel better? (i.e. rest or movement, medications, certain positions etc.) _____
 What makes it feel worse? _____
 If you feel pain or another sensation, what does it feel like? (i.e. aching, deep, stabbing, burning, tingly or numb etc.) _____
 Is this problem Worsening Improving Not changing
 Have you had this problem before? Yes No If yes, when? _____
 If yes, how did you treat it? _____
 Did it resolve then? Completely Partially Not at all
 What other treatments have you received for this problem?
 Medicine Acupuncture Massage therapy Surgery Chiropractor Exercise/Pers. Training None
 Other physical therapy Therapist's/Clinic name? _____
 Other treatment/provider Treatment/Provider's name? _____
 What has been most helpful for this problem? _____
 What tests and imaging have you had for this problem?
 X-ray MRI CT Scan Nerve conduction study Bloodwork Ultrasound Other None
 Please rate your level of pain (0=no pain; 10=worst pain): On Average _____ At Worst _____ At Best _____
 What are your most important goals for your treatment with us? (what do you hope to get out of therapy?)
 Goal #1 _____
 Goal #2 _____
 Goal #3 _____

Use a pencil or pen to indicate the body areas where you are experiencing pain or discomfort.





SHORT-NOTICE CANCELLATION AND MISSED-APPOINTMENT POLICY

Thank you for choosing Focus Physical Therapy, Inc. for your care! We pride ourselves in our expert team and specialized care and will tailor your treatment to your specific needs in each one-on-one, hour long appointment. Your appointment time was scheduled exclusively for you and in an effort to best accommodate your schedule. We ask for the same courtesy and will do our best to make sure that we run on time and make each appointment valuable to you and your needs. As a result of the time and energy placed into your treatment plan, we require a minimum 24-hour cancellation notice.

SHORT-NOTICE CANCELLATIONS

Emergency situations and personal illnesses do occur that may make it impossible to keep a scheduled appointment. In those instances, we will not charge you the missed appointment fee of \$35. Please be advised that a second cancellation of an appointment outside of the required 24-hour notice period will result in a fee of \$35. The cancellation fee is not billable to your insurance provider or worker's compensation payer and is your responsibility. You may call any of our offices at any time to speak with a representative or to leave a message on our answering machines to notify us of any changes to your previously scheduled appointment. Keep in mind that should your therapist encounter an emergency situation or become ill and your appointment is rescheduled as a result, you will not be assessed a fee.

Additionally, when patients do cancel appointments, we will make every effort to minimize the impact to our therapist's schedules. We may, on occasion, contact patients to see if moving them to another time is convenient for both parties. If you are able to accommodate we sincerely appreciate your flexibility. By the same token, if you find that you have a schedule change that conflicts with your previously scheduled appointment, we encourage you to call as quickly as possible to reschedule. If the required schedule change falls outside of the 24-hour notice period but one that we can easily accommodate you will not be assessed the cancellation fee of \$35.

If we are billing a motor vehicle insurance provider for an existing claim, you cannot be assessed a cancellation fee for missed appointments. Please be advised that we may elect to discontinue your treatment after three missed appointments for those who do not adhere to our policy. Please note as of April 1, 2019, worker's compensation patients must also pay for short-notice cancellation fees.

MISSED/NO SHOW APPOINTMENTS

Any missed appointment without notice, unless it falls under one of the exceptions mentioned above, will be charged at \$120 to your account and is not covered by insurance, including worker's compensation payers.

Please note as of April 1, 2019, worker's compensation patients must also pay for missed/no show appointment fees.

If we are billing a motor vehicle insurance provider for an existing claim, you cannot be assessed a cancellation fee for missed appointments. Please be advised that we may elect to discontinue your treatment after repeated late or missed appointments for those who do not adhere to our policy.

Signature of Patient or Responsible Party

Date



FINANCIAL POLICY

Welcome to Focus Physical Therapy, Inc.! In an effort to make ensure your rehabilitation and treatments with Focus are as stress free as possible we have established a clear financial policy. Below outlines information specific to all aspects of the financial responsibility associated with your recovery. Please read carefully and sign where indicated. A copy of this form will be issued to you upon request.

Focus partners with most regional insurance plans. If you are not insured by a plan that we conduct business with payment in full will be expected at each visit. All patients are encouraged to contact their insurance provider for verification or clarification of allowed benefits. Knowing your insurance benefits is your responsibility. In most cases, Focus will bill your provider, however any account balance incurred with Focus is legally your responsibility. The adult, parent or legal guardian accompanying a minor dependent is financially responsible for all services rendered by Focus and agree to all terms listed herein.

If Focus will be billing a workers' compensation carrier or motor vehicle insurance provider it is imperative that we receive your claim information as quickly as possible. We will also require a copy of your personal insurance information in the event that your workers' compensation or motor vehicle accident claim is denied.

Should your account become overdue our policy is to turn the account over to a collection agency. Any legal fees paid to secure overdue balances will be added to your account and treatment with our facility may be terminated.

Terms of Agreement

I, the undersigned, hereby agree with the following:

- All co-payments and deductibles must be paid at the time of service. This arrangement is part of my contract with my insurance company. Failure on the part of Focus to collect co-payments and deductibles from patients may be considered fraudulent. I agree to pay my co-payment and/or deductible at each visit.
- I am aware that some, and perhaps all, of the services/equipment I have received may be non-covered, denied by my carrier or not considered reasonable or necessary by Medicare or other providers. I understand that I am financially responsible for all charges not paid by my insurance company.
- I will present a copy of a current, valid insurance card to provide proof of my existing insurance coverage. I will notify Focus of any change in my information, including but not limited to, address, phone number or insurance coverage.
- My insurance company may need for me to supply certain information directly. It is my responsibility to comply with all requests. I am aware that insurance coverage does not guarantee payment of services.
- I certify that I (or my dependent) have insurance coverage as provided to Focus and assign directly all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges not paid by my insurance provider. I hereby authorize the release of all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.
- I understand that I may be assessed a charge of \$120 for no show appointments and \$35 for not canceling within 24-hours of my scheduled appointment time. These charges are my responsibility and not covered by my insurance.

Signature of Patient or Responsible Party

Date



CONSENT FOR TREATMENT

I, the undersigned, voluntarily consent to the use or disclosure of my protected health information by Focus Physical Therapy, Inc. for the express purpose of providing treatment, obtaining payment for my health care costs or to conduct health care operations. I understand that treatment may be conditional upon my consent.

I understand that I have the right to request a restriction as to how my protected health information is utilized or disclosed in order to carry out treatment, receive payment or other health care operations of the clinic. Focus is not obligated to agree to my stated restrictions. I understand that should Focus agree to my stated restrictions that it will be binding on Focus and my physical therapist. I have the right to revoke this consent in writing, at any time, except to the extent that my physical therapist and Focus have taken action in reliance on this consent.

My protected health information consists of any health information, including my demographic information, collected from me and created or received by my physical therapist, other health care providers, a health plan, my employer, or a health care clearinghouse. This protected health information may relate to my past, present or future physical or mental health or any other condition that identifies me, or when there is a reasonable basis to believe the information may identify me.

I authorize the release of any medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

I have personally received a copy of the Notice of Privacy Practices prior to signing this Consent for Treatment. This notice describes the variety of uses and disclosures of my protected health information that may occur during my treatment with Focus. The notice also outlines my rights and responsibilities with respect to my protected health information. I understand that Focus has the right to alter their Notice of Privacy Practices at any time. When changes are made to the policy, Focus will notify me in writing upon my next visit.

I hereby authorize Focus to administer treatment as is necessary. I also certify that no guarantee or assurance has been made as to the results that may be obtained. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance directly to me and that I am personally responsible for the payment.

I hereby authorize the insurance company/insurance administrator to pay by check or electronic funds transfer (EFT) and for it to be mailed directly to Focus the expense benefits allowable, and otherwise payable to me under my current policy, as payment toward the total charges for professional services rendered, and I have agreed to pay, in a current manner, any balance of professional charges.

I direct my attorney to pay any outstanding expenses from my settlement, and in effect, protect any such balance. I fully understand that I am directly responsible for all medical bills and this agreement is made solely for the physical therapist's additional protection and consideration for his/her awaiting payment. I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover. I have been advised that if my attorney does not wish to cooperate in protecting this physical therapist's interest, the physical therapist will not await payment, but require me to make payment on a current basis.

Signature of Patient or Responsible Party

Date



ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

(To be retained by Medical Provider)

I understand that Focus Physical Therapy, Inc. (referred to below as “the clinic”) will use and disclose health information about me in the course of providing physical therapy care to me. I understand that my health information may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar health-related information.

I understand that the clinic is permitted to use and disclose my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to/or consult and coordinate with other health care providers in the course of my treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support the clinic’s ability to provide me with appropriate care and arrange for payment.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request and that a copy or a summary of the most current version of the clinic’s Notice of Privacy Practices in effect will be posted in waiting/reception area and available on website at focusptbend.com.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the clinic is not required by law to agree to such requests.

By signing below, I agree that I have received or been offered a copy of this clinic’s Notice of Privacy Practices.

By: _____ Date: _____
(Patient)

-OR

By: _____ Date: _____
(Patient representative)

Description of Representative’s Authority: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify) _____