FOCUS PHYSICAL THERAPY

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 _____ My preferred pronouns are
Date of Birth _____ 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 _____ 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)

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

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? _____

FOCUS PHYSICAL THERAPY

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:

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

HEALTH HISTORY

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

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

FOCUS PHYSICAL THERAPY

Patient Name:_____DOB:_____

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 _____

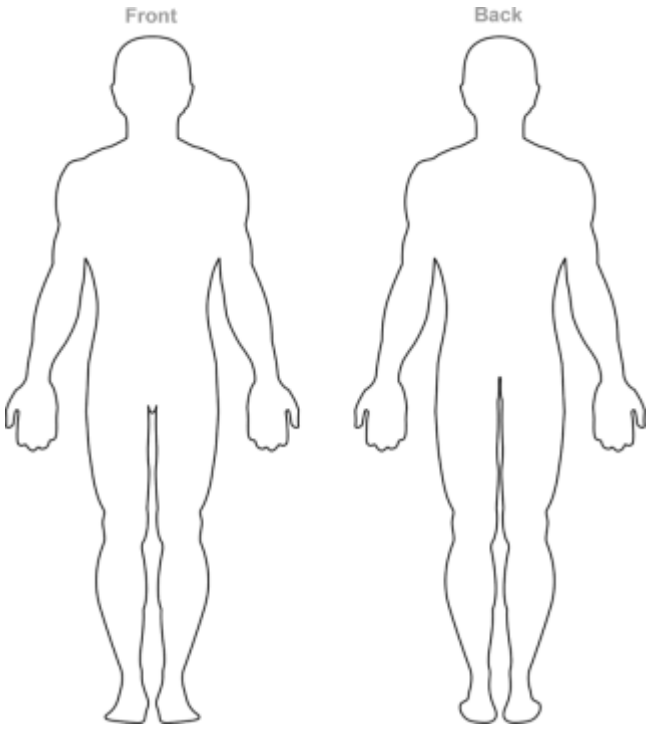
What are your most important goals for your treatment with us? (what do you hope to get out of therapy?)

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 Medicaid, or a Motor Vehicle insurance provider for an existing claim, you cannot be assessed a cancellation fee. Please be advised that we may elect to discontinue your treatment after two 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 Medicaid or a motor vehicle insurance provider for an existing claim, you cannot be assessed a fee for missed appointments. Please be advised that we may elect to discontinue your treatment after two 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 more than 30 days overdue we charge 9% finance charges per month of the incurred balance. After 90 days delinquency our policy is to report your account to a credit bureau, then 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 deposits for deductibles and coinsurance plus any accrued balance on your account 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 estimated payment plus accrued balance 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 my ID and 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 9% monthly finance charge for balances accrued over 30 days. 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**

Credit Card on File Authorization Form

Please complete all fields. You may change or cancel this authorization at any time by contacting us.
This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card):
Card Number:
Expiration Date (mm/yy): CCV
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize Focus Physical Therapy to charge my credit card above for any current estimates plus outstanding balances for myself and/or the patients listed below. I understand that my information will be saved to a secure file for future transactions on my account.

Patient Name: _____ DOB _____

Patient Name: _____ DOB _____

Patient Name: _____ DOB _____

_____ _____

Credit Cardholder Signature Date

CONSENT FOR TREATMENT

FOCUS PHYSICAL THERAPY

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**

FOCUS
PHYSICAL THERAPY

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) _____