Clegg & Guest Physical Therapy
Committed to Excellence. Committed to You.

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Consent for Treatment - Authorization for Payment - Admission, Cancellation, & Financial Policy

Consent to Outpatient Therapy Services: I request and authorize outpatient care as my physical therapist, in consultation with my physician, may deem necessary or advisable. I understand that care is directed by my physician and that the physician who directs the care is independent and not an agent, representative or employee of this facility. I understand that in emergency situations it may be necessary or advisable for additional or extended services beyond those contemplated at the time of admission in order to preserve the patient's health or life. In the event there is a potential blood or body fluid exposure to a healthcare worker or other facility employee, I consent to the administration of an HIV and HBV Antibody test.

Payment Authorization: I authorize direct payment of benefits otherwise payable to me, to this facility. I understand that I am financially responsible to Clegg & Guest Physical Therapy for charges that are not covered by this assignment. I authorize any holder of medical or other information about me to release such information as necessary to process these claims related to my medical condition/treatment. I authorize the Social Security Administration Office and Center for Medicare Services to release any information about me as necessary to process claims related to my medical condition/treatment. I permit a *copy* of this authorization to be used in place of the original. I understand that my insurance contract is a relationship between myself and the insurance company, not with this facility. I am aware of my coverage benefits and exclusions.

Admission to Facility: It is very important that you, the patient, inform us, the provider, upon admission to our facility, the circumstances surrounding your injury. In certain instances, if incomplete or incorrect information was provided by the patient or provider or if any pertinent information was withheld, an insurance company may recover payment. It is your responsibility to also inform us of any home health services, prior physical therapy, chiropractic care, or hospitalizations that occur during your course of therapy. These services may affect the payment of your physical therapy treatment.

Cancellation of Appointments: We will attempt to schedule your therapy appointments when you would like to have them, so that they are left reserved just for you. We request a 24 hour cancellation notice so that we may schedule other patients for that time, equipment, and personnel. You have 5 business days to make up missed appointments, which start the day your appointment is missed. We are not allowed to add these days to the end of your therapy. Failure to notify the office of a cancellation, or failure to show up for a scheduled appointment will result in a $50.00 service charge to your account, which is not payable by your insurance company. Repeated failure to contact us when an appointment is missed may result in discharge from physical therapy.

Financial Policy: By signing this page, you understand and agree that the filing of insurance claims is a courtesy that we extend to our patients. As a medical care provider, our relationship is with you, not with your insurance company. Some insurance companies do not cover certain services, such as foot orthotics, etc. You are responsible for all charges regardless of existing medical coverage on file. If for any reason your services are denied, we will make every reasonable effort to appeal, however please understand that all charges are your responsibility.
Any account balances that are billed to you must be paid in full. If you are not able to make full payment by the statement due date, please inquire at our front office to set up payment arrangements. If you fail to respond to statements or fail to comply with a written payment arrangement, we may forward your account to a collection agency, which will result in "credit reporting" to the credit bureaus. You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collections efforts.
Payments may be made by cash, check, or by Visa or MasterCard. Visa and MasterCard payments may be made by phone. A returned check fee or returned ACH fee of $40.00 will be charged to your account for all returned checks or returned ACH (electronic) payments.

I have read the above information given to me. I understand this information and agree to all of the terms therein for admission to physical therapy.

Patient or Parent/Legal Guardian Signature: _____ Date: _____/____/_____

Printed Name of Patient or Parent/Legal Guardian: _____

The answers to the following questions may affect your coverage/benefits/claims, as well as your treatment at our facility. Please carefully review and complete each question. If you have any questions, please ask a member of our front office staff.

Have you had any **TESTS** performed related to this condition (X-Rays, MRIs, etc)? O YES O NO

Date of TEST	Type of Test	Ordering Physician	Phone Number
_____/_____/_____	_____	_____	(_____)_____
_____/_____/_____	_____	_____	(_____)_____

Is your condition related to a liability accident? O YES O NO (If YES, complete the section below)

Date of accident/injury: _____/_____/_____ State in which injury occurred: _____

O Work related O Auto accident related O Other liability injury

Please explain the accident: (**If auto related, list specific details of accident: driving/walking, types of cars, etc)**

_____

_____

Assigned Adjuster: Name: _____ Phone: (_____) _____

Assigned Case Manager: Name: _____ Phone: (_____) _____

Retained Attorney: Name _____ Phone: (_____) _____

Are you involved in any lawsuit/litigation relating to this condition? O YES O NO

Are you receiving any medical services in your home? O YES O NO
If YES, What type? _____

Have you received any physical, occupational, or speech therapy this year? O YES O NO
If YES, where _____ For how long? Months _____ Weeks _____

Have you received any chiropractic care this year? O YES O NO
If YES, how many visits? _____

Have you seen an athletic trainer this year? O YES O NO
If YES, how many visits? _____

If you are hospitalized for any reason during the course of therapy, you must notify us immediately.

If you have any changes to your insurance (including receiving new insurance cards), please notify our office and bring any new cards to your next visit.

The information on this page is true and complete. I understand that the filing of insurance claims is a courtesy provided to me. I agree to provide timely, accurate, updated information to Clegg & Guest PT to facilitate the processing of my insurance claims.

Patient or Parent/Legal Guardian Signature: _____ Date: _____/_____/_____

Printed Name of Patient or Parent/Legal Guardian: _____

Acknowledgement of Notice of Privacy Practices

The privacy of your medical information is very important to us. If you have questions or concerns about your privacy, please let us know. Please be aware that the person(s) that you provide as Emergency Contacts may be given limited information regarding your care as defined in our notice of privacy practices.

Who may we contact on your behalf, in case of an emergency?

Contact: _____ Relationship to Patient:_____
First Name Last Name (required)

Phone: Primary: (_____) _____ Secondary: (_____) _____
O Home O Cell O Work O Home O Cell O Work

Contact: _____ Relationship to Patient:_____
First Name Last Name (required)

Phone: Primary: (_____) _____ Secondary: (_____) _____
O Home O Cell O Work O Home O Cell O Work

How did you choose Clegg & Guest Physical Therapy for your treatment?

__ I am a previous patient of Clegg & Guest PT.
__ My doctor referred me directly.
__ Your name was on the prescription.
__ Your location is convenient-- Close to my: O Home O Work O Other
__ I found you on the internet: O Facebook O Google O CGPT Website O Other
__ I was referred by another patient (Please tell us who to thank!)_____
__ I was referred by another therapist (Please tell us who to thank!) _____
__ I was referred by one of your employees (Please let us know who to thank!) _____
__ Other, please explain: _____

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I have received, read, & understand the detailed Notice of Privacy Practices from this facility. (can be found at www.cgphysicaltherapy.com)

Patient or Parent/Legal Guardian Signature: _____ Date: ____/_____/_____

Printed Name of Patient or Parent/Legal Guardian: _____

********** FOR OFFICE USE ONLY **********

Documentation of Good Faith Efforts

The above patient presented for treatment on this date and was provided with a copy of Clegg & Guest Physical Therapy's Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgement of receipt of the notice. However, an acknowledgement was not obtained because:

_____ Patient refused to sign _____ Patient was unable to sign because_____
_____ There was a medical emergency (CGPT will attempt to obtain at the next appointment)
_____ Other reason, give details: _____

Signature of employee completing form: _____ Date: _____ /_____/_____

Medical History

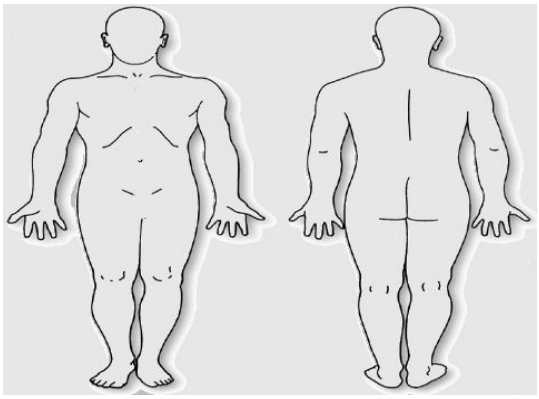
Last Name: _____ First Name: _____ D.O.B. _____/_____/_____

Please mark either Yes or No for <u>each item</u> below. If you need additional space, write on a separate sheet of paper.

Allergies	O Yes O No	Diabetes	O Yes O No	Metal Implants	O Yes O No
Anemia	O Yes O No	Dizzy Spells	O Yes O No	MRSA-Staph Infection	O Yes O No
Anxiety	O Yes O No	Emphysema/Bronchitis	O Yes O No	Multiple Sclerosis	O Yes O No
Arthritis	O Yes O No	Fibromyalgia	O Yes O No	Muscular Disease	O Yes O No
Asthma	O Yes O No	Fractures	O Yes O No	Osteoporosis	O Yes O No
Autoimmune Disorder	O Yes O No	Gallbladder Problems	O Yes O No	Parkinson's	O Yes O No
Cancer	O Yes O No	Headaches	O Yes O No	Rheumatoid Arthritis	O Yes O No
Cardiac Conditions	O Yes O No	Hearing Impairment	O Yes O No	Seizures	O Yes O No
Cardiac Pacemaker	O Yes O No	Hepatitis	O Yes O No	Smoking History	O Yes O No
Chemical Dependency	O Yes O No	High Cholesterol	O Yes O No	Speech Problems	O Yes O No
Circulation Problems	O Yes O No	High/Low Blood Pressure	O Yes O No	Strokes	O Yes O No
Had Covid-19	O Yes O No	HIV/AIDS	O Yes O No	Thyroid Disease	O Yes O No
Currently Pregnant	O Yes O No	Incontinence	O Yes O No	Tuberculosis	O Yes O No
Depression	O Yes O No	Kidney Problems	O Yes O No	Vision Problems	O Yes O No

Please describe any other conditions or concerns here:

Please indicate problem areas on the drawing below



Height: _____ **Weight:** _____

<u>Falls History</u>

Is the injury the result of a fall in the past year? O Yes O No Date of Fall: _____

Two or more falls in the last year? O Yes O No Dates of Falls: _____

Patient is at risk for falls? O Yes O No _____

<u>Surgical History</u> ☐ I have no surgical history ☐ Returning patient: Only list new surgery after: _____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____/_____/_____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____/_____/_____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____/_____/_____

<u>Current Medications</u> ☐ I do not take any medications ☐ Separate medication list attached

Drug: _____ Dosage: _____ Frequency: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Reason for Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Reason for Taking: _____