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

35413 Schoenherr Rd.
Sterling Heights, MI 48312-4258

Phone: (586) 978-7900
Fax: (586) 978-7710

Email: frontdesk@cgphysicaltherapy.com
Website: www.cgphysicaltherapy.com

Consent for Treatment, Authorization for Payment, Admission & 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 treatment. ***If you are hospitalized for any reason during the course of therapy, you must notify us immediately.**

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 35% 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: _____

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Cancellation Policy

At Clegg & Guest Physical Therapy, we are committed to providing the highest level of care and service to all our patients.

In order to maintain this standard, we have updated our cancellation policy to ensure fairness to both our patients and our staff.

Our Policy:

24-Hour Notice: We kindly request that you provide at least 24 hour notice if you need to cancel or reschedule your appointment. This allows us to offer the appointment time to another patient in need of care.

Late Cancellations/No-Shows: Appointments cancelled with less than 24 hour notice or missed without notice will be subject to a cancellation fee of $50.00. (Your insurance company will not pay for this).

Emergencies: We understand that emergencies happen. If an unexpected situation arises, please contact us as soon as possible to reschedule your appointment.

Repeated failure to contact our office may result in discharge from therapy.

Why This Policy Is Important:

Our therapists dedicate their time to providing individualized care to each patient. When an appointment is cancelled without sufficient notice, it limits our ability to offer that time to another patient who may be waiting for treatment. Consistent attendance is also critical to achieving the best outcomes in physical therapy, so this policy helps support the continuity of your care as well.

We value your understanding and cooperation in helping us ensure that everyone receives timely, quality care.

If you have any questions regarding this policy, please do not hesitate to reach out to our office at (586)978-7900.

I have reviewed and understand the cancellation policy and agree to the terms noted.

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

Printed Name of Patient or Parent/Legal Guardian: _____

Additional Information for Treatment and Insurance Claims

The following 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 our staff.

Have you received any physical, occupational, or speech therapy this year? O NO O YES:

Where? _____ For how long? Months: _____ Weeks: _____

Have you received any chiropractic care this year? O NO O YES: How many visits? _____

Have you seen an athletic trainer this year? O NO O YES: How many visits? _____

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

Date of Test:	Type of Test:	Ordering Physician:
_____/_____/_____	_____	_____
_____/_____/_____	_____	_____

How Did You Choose Clegg & Guest Physical Therapy For Your Treatment?

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

Emergency Contacts & Acknowledgement of Notice of Privacy Practices

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.

1) Contact: _____ Relationship to Patient: _____
First Name Last Name

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

2) Contact: _____ Relationship to Patient: _____
First Name Last Name

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

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 read & understand the detailed Notice of Privacy Practices from this facility. (This can be found at cgphysicaltherapy.com/library_privacy, or on intake clipboard.)

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, it 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)

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

Medical History

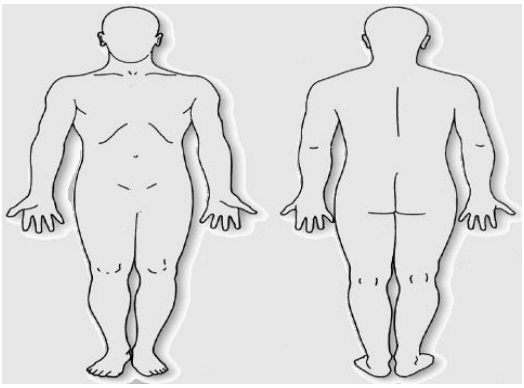
Last Name: _____ First Name: _____ D.O.B. _____/_____/_____

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 Disease: 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
Chem. 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: _____ft _____in **Weight:** _____lbs

Fall History:

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

Two or more falls in the last year? O NO O YES: Dates of Falls: _____

Is patient at risk for falls, or noticing weakness in stability or balance? O NO O YES

Surgical History: O I have no surgical history. O Returning patient -- Only list new surgery since last intake:

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

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

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

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

Current Medications: O I do not take any medications. O 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: _____

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