First Contact & Treatment Consent

How did you find us?	Brochure ___ Newspaper ___ Magazine ___ Doctor Referral ___ Dr's Name___________ Former client ___ Referral ___ Referrals Name ____________Other ___			
Condition	Area of pain/problem		Date pain/problem began	
	How injury occurred	θ Work θ Auto θ Other	Date of similar pain/problem in past	
	Impairments? θ Sleep θ Bathroom θ Sit θ Walk θ Other:		θ Worsening θ Better θ Same	θ Hospitalized θ Missing work Since when?
Patient Info	Patient Name (Last, First)	Age	DOB	θ Male θ Female
	Hm Phone / Other Phone	Email		
	Mailing Address	City		State & Zip
		Social Security #		

Payment Information	PRI WC LIEN MC AUTO SELF-PAY (discount/CC info to reserve) PAY PLAN other:			
	Insurance Company Name / Phone #		Referring Physician	
	Street Address		City	State/Zip
	Subscriber Name (if other than self)	θ Parent θ Spouse θ Other / DOB	ID #	Group #
	(WC only) Claim Number / Adjuster Name		Phone #	Date of injury
	Employer Name	Occupation	Employer Phone	
	Emergency Contact Name	Relationship	Emergency Contact Phone	
		Comments:		

Consent For Treatment

I hereby give consent to the physical therapist and staff of Ascent Physical Therapy to render such care as might be related to my condition. Such care can include, but is not limited to physical examinations, modalities, manual therapy, and exercise.

Patient/Parent/Guardian

Signature____ Date____________________

If other than patient indicate relationship____

Financial and Insurance Plan Policy

We take pride in the high-level quality of our services. You have made an excellent decision by choosing to resolve your functional problems with Ascent Physical Therapy. In order to provide you with the best possible care, please address the following policies.

- Payment for services is due at the time of services are rendered unless payment arrangements have been approved in advance by our staff.
- We accept cash, checks, MasterCard, Visa and American Express.
- Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1.5% per month.
- A $25 charge will be assessed for no-show appointments and appointments cancelled without 24 hour advance notice.

We are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

- If you request, we will help you process your insurance claim-form for your reimbursement. Any such request must be accompanied by a completed insurance form at each visit.
- You may also assign your benefits to us and we will deal directly with your insurance company on your behalf.
- We will gladly discuss your proposed treatment and answer any questions related to your insurance. You must realize, however, that:

    - Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.

    - Our fees are considered to fall with in the acceptable range by most companies, and therefore are covered up to maximum allowance determined by each carrier. This applies only to companies that pay a percentage such as 50% or 80% or “UCR”. “UCR” is defined a usual, customary, and reasonable. (This statement does not apply to companies that reimburse based on an arbitrary schedule of fees which bears not relationship to the current standard and cost of care in this area).

- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information of any uncertainty regarding your insurance coverage PLEASE don’t hesitate to ask us. We are here to help you.

Patient name: ____ Date:________________________

Patient Signature: ____

Assignment of Benefits to Ascent Physical Therapy

Patient Name:____

Insurance Policy #:____

Insured Name:____

Claim #____

I hereby instruct and direct ____________________ insurance company to pay by check made out and mailed to:

Ascent Physical Therapy
90 Lake Street
Avon, CO 81620
(970)949-9966

If my/this current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and **<u>mail it to the above address</u>** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

- ❑ A photocopy of this Assignment shall be considered as effective and valid as the original.
- ❑ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- ❑ I authorize the use of this signature on all insurance submissions.
- ❑ I authorize Ascent Physical Therapy to deposit checks made in my name.
- ❑ I authorize Ascent Physical Therapy to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- ❑ I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this ______ day of ______________, 20_____.

______________________________	______________________________
Signature of Policyholder	Witness

____
Signature of Claimant, if other than Policyholder

ASCENT PHYSICAL THERAPY PAYMENT PLAN AND POLICIES

To the **insured** patient:

Your insurance is a contract between you, the insurance company, and the employer. We are not a party to that contract.

Payment for services is due at the time of service. If you request, we will help you process your insurance claim form for your reimbursement. Any such request must be accompanied by a **completed** insurance form at each visit.

Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage such as 80% of "UCR". UCR is defined usual, customary, and reasonable. This statement does not apply to companies that reimburse based on an arbitrary "schedule" of fees which bears no relationship to the current standard and cost of care in this area. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

☐ I will pay at the time of service and get insurance reimbursement on **my own**. 30% savings.

☐ I will sign the form "Assignment of Benefits" and would like to have you **deal directly** with my insurance company.

Signed:___________________________________

Date:__________________

To the **UN-insured** patient:

You've made an excellent decision by choosing to resolve your pain and problem with us here. As a self-paying client you are entitled to a 30% discount off all our services if payment is made at the time of service.

We accept cash, check, MasterCard, Visa, and American Express. We take pride in the high quality of our services and stand behind it with a 100% satisfaction guarantee!

☐ I will pay at the time of service and take advantage of the 30% savings!

☐ I would like to request a payment plan arrangement and pay the **full price** for your services.

Signed:______________________________________

Date:____________________

DO NOT BE LATE

More than 10 min to your appointment or you will need to reschedule.

GIVE 24-HOUR ADVANCE NOTICE

No shows or cancellations made to your appointment within 24 hrs will incur a $25 fee and be applied to your account.

NO-SHOWS ARE BAD

We understand things happen. If you are unable to keep your appointment please call us and let us know. Simply not showing up will result in the loss of all previously scheduled future appointments. New appointments will be allowed on a "first-come, first –serve basis".

ASCENT PHYSICAL THERAPY
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Ascent Physical Therapy is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

> *"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Ascent Physical Therapy."*
>
> *"It is our policy to provide a substitute health care provider, authorized by Ascent Physical Therapy to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations.
(example)

> "*As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Ascent Physical Therapy for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.
We may disclose your health information to coroners or medical examiners.

Organ Donation.
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research.
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety.
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing.
We may contact you for marketing purposes or fundraising purposes, as described below: (example)

"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Ascent Physical Therapy sponsored fund-raising events."

Change of Ownership.
In the event that Ascent Physical Therapy is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Ascent Physical Therapy is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that Ascent Physical Therapy amend your protected health information. Please be advised, however, that Ascent Physical Therapy is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Ascent Physical Therapy.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
Ascent Physical Therapy reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Ascent Physical Therapy] is required by law to comply with this Notice.

Ascent Physical Therapy is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Keith McCarroll by calling this office at (970)949-9966. If Keith is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints
Complaints about your Privacy rights, or how Ascent Physical Therapy has handled your health information should be directed to Keith McCarroll by calling this office at (970)949-9966. If Keith is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of ______/______/_______

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Ascent Physical Therapy] with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

____
Patient's Name (print)

____ ______________
Patient's Signature Date

____ ______________
Authorized Facility Signature Date

NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS (NEMB)

There are items and services for which Medicare will not pay.

- Medicare does **not** pay for all of your health care costs. Medicare pays only for covered benefits.
  Some items and services are not Medicare benefits and Medicare will not pay for them.

- When you receive an item or service that is **not** a Medicare benefit, **you are responsible to pay for it,** personally or through and other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself.
Before you make a decision, you should read this entire notice carefully.
Ask us to explain, if you don't understand why Medicare won't pay.
Ask us how much these items or services will cost you (**Estimated cost**: $_____________).

Medicare will not pay for: Physical Therapy and Speech Language Pathology services over $1740.00 in 2007.

☐**1. Because it does not meet the definition of any Medicare benefit.**

☐**2. Because of the following exclusion * from Medicare benefits.**

☐ Personal comfort items.
☐ Most shots (vaccinations).
☐ Hearing aids and hearing examinations.
☐ Most outpatient drugs.
☐ Orthopedic shoes and foot supports (orthotics).
☐ Health care received outside of the USA.
☐ Services required as a result of war.
☐ Routine Physicals and most tests for screening.
☐ Routine eye care, eyeglasses and examinations.
☐ Cosmetic surgery.
☐ Dental care and dentures (in most cases).
☐ Routine foot care and flat foot care.
☐ Services by immediate relatives.
☐ Services under a physician's private contract.
☐ Services paid for by a government entity that is not Medicare.
☐ Services for which the patient has no legal obligation to pay.
☐ Home Health Care Services furnished under a plan of care, if the agency does not submit the claim.
☐ Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997.
☐ Items or services furnished in a competitive acquisition area by any entity that does not have a contract with the Department of Health and Human Services (except in a case or urgent need).
☐ Physicians' services performed by a physician assistant, midwife, psychologist, or nurse anesthetist, when furnished to an inpatient, unless they are furnished under arrangements made by the hospital.
☐ Items and services furnished to an individual who is a resident of a skilled nursing facility (a SNF) or a part of a facility that includes a SNF, unless they are furnished under arrangements by the SNF.
☐ Services of an assistant at surgery without prior approval form the peer review organization.
☐ Outpatient occupational and physical therapy services furnished incident to a physician's services.

*** This is only a general summery of exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.**

Patient Signature: ____

Patient Name (Print): ______________________________________ Date: __________________