Foothills Physical Therapy, P.A.
and Fitness Center / Gym

16 Old Pike Rd
Cornish, ME 04020
(207) 625-4300

PATIENT INFORMATION			EMAIL ADDRESS:_____
First Name:	Last Name:	Middle Initial:	Date: / /
Address:	City:	State:	Zip:
Birth date: / /	Age:	☐ Male ☐ Female	S.S. #: - -
Home Phone: ( ) -	Alternative Phone (Cell, Pager): ( ) -		Spouse:
Chose Clinic Because/ Referred to Clinic By ☐ Dr.:		☐ Insurance Plan ☐ Family ☐ Friend	
☐ Former Patient ☐ Close to Work/Home ☐ Website ☐ Yellow Pages ☐ Street Sign ☐ Other:			

WORK INFORMATION		
Employer:	Work Phone ( ) -	Ext.
Occupation:	Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed	

CARE PROVIDER INFORMATION	
Referring Dr:	Referring Dr. Phone: ( ) -
Regular Dr./PCP	Regular Dr./PCP Phone: ( ) -

INSURANCE INFORMATION	(PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)
Primary Insurance Name:	
Subscriber's Name (If different):	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	
Name of Secondary Insurance:	
Subscriber's Name:	Birth date : / /
ID. #:	Group/Policy #
Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:	

AUTO OR WORK INJURY CLAIM	(PLEASE PROVIDE YOUR INSURANCE INFORMATION FOR BACKUP)		
Insurance Name: ☐ Auto :	☐ Labor & Industries:		
Adjuster/Claim Manager:	Phone:	Ext.:	
Address:	City	State:	Zip:
Claim #:	Accident Date: / /	Cause:	

ATTORNEY INFORMATION			
Name:	Law Firm:	Phone: ( ) -	
Address	City	State:	Zip:

IN CASE OF EMERGENCY		
Name of Local Friend or Relative (Not Living at Same Address):		
Relationship to Patient:	Home Phone: ( ) -	Work Phone: ( ) -

I authorize my insurance benefits be paid directly to Foothills Physical Therapy, P.A. I understand that I am financially responsible for any balance. I also authorize Foothills Physical Therapy, P.A. to release any information required to process my claims.

PATIENT /GUARDIAN SIGNATURE DATE

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PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE	YES	NO
Hypertension	☐	☐
Low Blood Pressure	☐	☐
Normal Blood Pressure	☐	☐

HEART DISEASE	YES	NO
Heart Attack	☐	☐
Atherosclerotic Disease	☐	☐
Myocardial Infarction	☐	☐
Rheumatic Heart Disease	☐	☐
Heart Murmur	☐	☐
Do you have a pacemaker	☐	☐

MUSCLE CONDITION	YES	NO
Carpal Tunnel R/L	☐	☐
Tennis Elbow R/L	☐	☐
Back/Neck Problems	☐	☐
Limited Limb Movement	☐	☐

LUNGS	YES	NO
Asthma	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

JOINT CONDITIONS	YES	NO
Upper Extremity	☐	☐
Dislocation	☐	☐
Lower Extremity Dislocation	☐	☐

OTHER CONDITIONS	YES	NO
Muscular Dystrophy	☐	☐
Rheumatoid Arthritis	☐	☐
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Gout	☐	☐
Fibromyalgia	☐	☐
Diabetes	☐	☐
Hearing Loss	☐	☐
Poor Eyesight	☐	☐
Fainting	☐	☐
Polio	☐	☐

Other: _____

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS
☐ None	☐ Sitting	☐ Low	☐ Smoking Packs a Day ____
☐ 1-2 x Week	☐ Standing	☐ Medium	☐ Alcohol Drinks a Week ____
☐ 3-4 x Week	☐ Light Labor	☐ High	☐ Coffee/Soda Cups a Week ____
☐ 5+ x Week	☐ Heavy Labor		

What types of exercise do you perform? : _____

What things cause stress in your life? :

Are you taking any seizure medication? ☐YES ☐NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

☐YES ☐NO If yes list name: _____

List all medications you are currently taking: _____

List all surgeries in the past two years (Including dates): _____

Are you pregnant? ☐ YES ☐ NO What week?: _____

Have you had any injuries related to work? ☐ YES ☐ NO If yes list body part and date.: _____

Have you had any Auto Accidents ☐ YES ☐ NO If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? ☐ YES ☐ NO Where:

_____ _____

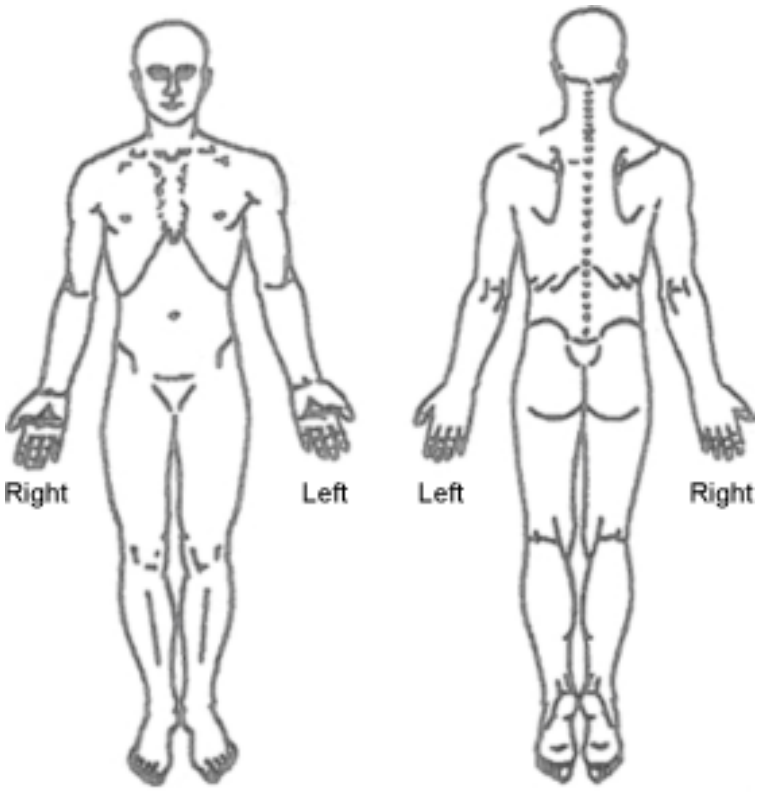
Signature of Patient, Parent, Guardian, Personal Representative Date

Pain and Symptom Status Report

Name _____ Date _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing.

Ache	Burning	Numbness
MMMM MM	– – – – –	OOOO OOO
Pins & Needles	**Stabbing**	**Other**
□□□□□□□□ □□□□□□	/ / / / / / / / / / / / /	x x x x x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____

Date First Symptom of Your Problem Occurred on: _____

2nd Complaint: _____

3rd Complaint: _____

Please circle on the scale below to indicate your <u>CURRENT</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**
Please circle on the scale below to indicate your <u>AVERAGE</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**
Please circle on the scale below to indicate your <u>WORST</u> level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**

Additional Comments: _____

_____

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CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information will be used by this practice, known as Foothills Physical Therapy, P.A. or disclosed to others for the purpose of treatment, obtaining payment or supporting the day-to-day health care operations of the practice.

We are providing you with a copy of our Notice of Privacy Practices. We request that you review the notice prior to signing this consent. You may request a restriction on the use or disclosure of your protected health information. If you wish to restrict your disclosure, you should make that request in writing.

This practice, however, may or may not agree to restrict the disclosure of your protected health information.

If we agree to your request, the restrictions will be binding. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

You may revoke the consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date of your revocation of consent is received will not be affected.

This practice reserves the right to modify the privacy practices outlined in the notice.

SIGNATURE

I have reviewed this consent form and have reviewed the Notice of Privacy Practices. I give my permission to this practice to use and disclose my health information in accordance with it.

_____
Name of Patient (Print Clearly)

_____
Signature of Patient Date

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient

Cancellation/No Show Policy

Attending your treatment sessions on a regular basis is essential to ensure that you receive the most benefit from your physical therapy. The front office staff will work with you to help find the best appointment slots to fit your schedule.

Foothills Physical Therapy P.A. requires a 24 hour notice for the cancellation of any scheduled appointment.

We understand that emergencies, poor winter road conditions and other scheduling conflicts may occur. Please call us as soon as you can. For these reasons, we allow for two consecutive cancellations without 24 hour notice. After two such occurrences however, a $40.00 fee will be charged per occurrence. If you are able to reschedule the missed appointment within the same week, no penalty will be assessed.

- After two consecutive no shows or cancellations without proper notice, you will be charged $40.00 per occurrence thereafter.
- This charge ***will not be covered*** by your insurance.

In the event that you need to cancel an appointment, for any reason, please call the office to let us know so that we can adjust our schedules accordingly.

Please take this policy seriously as it could impact payment from your insurer. Accident and Workers Compensation claims adjusters expect regular attendance and adherence to your plan of care.

Your pain may fluctuate as your course of treatment progresses. Having pain or *not* having pain are not reasons to cancel or fail to show for your scheduled treatment. If you are in pain, there are treatments available that can help lessen your pain. Likewise, if you are experiencing less pain, it is important to continue your treatments to correct the underlying causes of the pain. Missing appointments hinders that process and may end up prolonging recovery.

If you are ever unsure about attending an appointment due to pain, please call to speak with your physical therapist directly.

Thank you for providing us with this courtesy.

Signing below indicates you understand and agree to the terms of this policy.

_____ _____

Signature of Patient/Responsible Party if a minor Date

Payment Agreement

Thank you for choosing **FOOTHILLS PHYSICAL THERAPY, P.A.** as your physical therapy provider. To receive services from us, you agree to the following Payment Policies:

- You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.
- Payment is expected in full «at the time of service or within 30 days after receiving our bill» unless you have made other payment arrangements with us.
- Interest in the amount of 1 1/2% per month (18% annual interest rate per year) may be added to your bill for any and all claims that are not paid within thirty (30) days of the invoice or statement date. You agree to be personally responsible for paying such interest unless the responsible Payor is required to pay such interest under federal, state or other applicable laws.
- If we are in-network with your health plan, we will submit the claims to your health plan on your behalf and your health plan will send payment directly to us. If your health plan denies payment of our claims, in whole or in part, you are responsible for paying any and all unpaid amounts within thirty (30) days of receiving our statement regardless whether you have filed or plan to file an appeal. You hereby assign and convey directly to **FOOTHILLS PHYSICAL THERAPY, P.A.** all health plan benefits and/or insurance reimbursement benefits otherwise payable to me for medical services, treatments, therapies and/or examinations rendered or provided by us. You authorize Provider to release all medical information necessary to process my claims to the responsible Payor. You also hereby agree that if any payments are sent to you despite your assignment of benefits to us, you will promptly forward the funds and explanation of benefits/payment to Provider.
- If we are out-of-network, payment is expected in full at the time of service unless you have made other payment arrangements with us. We may, at our sole discretion, agree to set you up a payment plan or make other payment arrangements. We will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. We may agree to bill your health plan for our services directly and await payment from your health plan if you execute the assignment of benefits agreement below. You agree that if your health plan does not honor the assignment and sends payment to you, you will promptly forward the payments to us. You further agree that if your health plan denies payment of our claims, in whole or in part, you are responsible for paying any and all unpaid amounts within thirty (30) days of receiving our statement regardless whether you have filed or plan to file an appeal. We may, at our sole discretion, agree to bill your health plan directly if you assign your benefits to us by executing a separate Assignment of Benefits Agreement that we will provide.
- If your injury is work-related, we will bill your company's workers' compensation carrier if and only if you have filed an injury report with your employer and your right to workers' compensation benefits is not in dispute. If you are informed that a dispute about your right to workers' compensation benefits has arisen after you have begun treatment with us, you agree to inform us immediately. You will have a choice at that time to pay for your treatment out of pocket or allow us to bill your health insurance. In the event you do not have health insurance and cannot pay privately, we will discuss your options with you at that time.
- If an auto or other liability insurer is be responsible for paying your claims, you hereby assign your MedPay or other applicable benefits to us for the payment of our claims. You further agree to give us a lien on any settlement, judgment or insurance proceeds you receive for payment of any and all unpaid claims, including late payment interest and authorize your attorney to pay us out of the settlement/verdict proceeds. In the event your auto insurer or other liable party denies our claims or refuses to honor the assignment, we may, at our sole discretion, bill your health plan. If we do, you will be responsible for refunding any fees owed to your health plan when you settle your case. We may also, at our discretion, agree to wait until your case settles before requiring payment. If we do, you understand that we are not obligated to discount any portion of our service or interest fees when your case settles regardless of the amount of your settlement or whether your settlement adequately covers your balance due to us.
- You understand that you are responsible for filing all appeals of adverse benefit determinations. We are willing to file appeals on your behalf if you appoint us as your Authorized Representative (see below). By appointing us as your Authorized Representative, we are given the right by you to (1) obtain information regarding the claim to the same extent as you; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit or workers' compensation plan, health care benefit plan, or plan administrator. Our acceptance of the appointment as your Authorized Representative is no guarantee that your claims will be paid or alter your ultimate responsibility to pay our claims.
- You understand that we are not required to obtain your written authorization to disclose protected health information to a collection agency or court of law that may be necessary to collect payment for services rendered. Should collection proceedings or other legal action become necessary to collect an overdue account, you will be responsible for paying the collection costs plus court costs and filing fees incurred by the practice.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

X _____ Date: _____

Signature of Patient and/or Guardian

X _____ Date: _____

Signature of Provider Representative/Witness

Assignment of Benefits and Authorized Representative Appointment

☐ **Assignment of Benefits.** I hereby assign and convey directly to **FOOTHILLS PHYSICAL THERAPY, P.A.** all health plan benefits and/or insurance reimbursement benefits (including MedPay and/or Personal Injury Protection benefits), if any, otherwise payable to me for medical services, treatments, therapies and/or examinations rendered or provided by Provider regardless of its managed care network participation status. I hereby authorize Provider to release all medical information necessary to process my claims to the responsible Payor. I agree that if any payments are sent to me despite my assignment of benefits to Provider, I will promptly forward the funds and explanation of benefits/payment to Provider.

☐ **Appointment of Authorized Representative.** By checking this box, I hereby appoint Foothills Physical Therapy, PA (hereinafter "Provider") as my designated Authorized Representative to act on my behalf in the filing or pursuance of claims and appeals with my health plan, auto liability insurance plan or other liable Payor or Payors in connection with medical services, treatments, therapies and/or examinations rendered or provided by **FOOTHILLS PHYSICAL THERAPY, P.A.** regardless of its managed care network participation status. I understand that as a result of this authorization, the Payor(s), plan administrator, fiduciary, insurer and/or attorney may disclose and release information concerning benefit eligibility, claim status, or claim approval or denial reasons in connection with the above referenced health care claims to the Provider. Further, I hereby authorize my health plan, plan administrator, fiduciary, insurer, and/or attorney to release to Provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon request from Provider or its attorneys in order to claim such medical benefits. As my Authorized Representative, Provider is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit or workers' compensation plan, health care benefit plan, or plan administrator. Provider, as my Authorized Representative, Provider may also bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at Provider's expense. This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims.

Right to Revoke Designation and/or Assignment. I acknowledge that Provider has not made the provision of my medical care contingent upon this designation of Provider as Authorized Representative. I understand that I may revoke this Authorized Representative appointment at any time by giving written notice to Provider and Payor(s) except to the extent that any party has taken action in reliance on this appointment before they knew of the revocation. I further understand that revocation of Provider as my Authorized Representative does not release me from my obligation to pay Provider's claims. Unless revoked, this Authorized Representative appointment is valid for all administrative and judicial reviews under the Affordable Care Act, ERISA, Medicare and applicable federal and state laws until Provider's claims are paid in full.

A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

X _____ Date: _____

Signature of Patient and/or Guardian

X _____ Date: _____

Signature of Provider Representative/Authorized Representative