Patient Express Registration

ART OF HEALING PT
Physical Therapy and Myofascial Release Treatment Center

Today's Date:

1. Patient Info

Please Fill-Out Entire Form Completely & Legibly.

Last Name _____ First Name _____ Age _____ ❑ Male ❑ Female

Street Address _____ City _____ State _____ ZIP _____

(_____) Home Phone _____ (_____) Cellular _____ • Email Address (important) _____

Occupation _____ Employer Name _____ (_____) Phone # _____

Emergency Contact Person _____ (_____) Phone # _____ If Patient is a MINOR: Parent/Guardian Name and Signature Here _____

Social Security # _____ Date of Birth ____/____/____ ❑ Single ❑ Married ❑ Divorced

Work Status: ❑ Currently Employed: ❑ Retired ❑ Disabled (__Total or __Temporary) ❑ Student (__P/T __F/T)

2. My Condition Info

ALL INFO REQUIRED

My injury/ailment is related to . . .

❑ AUTO/PERSONAL INJURY: Date of accident: ____/____/____

❑ WORK INJURY: Date of injury: ____/____/____

❑ NO INJURY: What do you think may have caused it?

I have already had . . .

❑ PHYSICAL THERAPY BEFORE: When and where?

❑ HOME HEALTH Care: Are you still receiving it? __YES __NO

❑ OTHER care: What?

3. Payment Info

(Check only one box)

I am paying TODAY by . . .

❑ **INSURANCE** and would like to …

Have you deal directly with them. I will assign my benefits to you by completing the **"Assignment of Benefits Form"**

❑ **I AM A SELF PAY PATIENT** and would like to …

Get a 30% discount by paying at the time of service. I'll get reimbursement on my own. (Ask the front desk person for details) If applicable.

❑ I have an **ATTORNEY** and would like to . . .

Get a 30% discount by paying at the time of service. I'll get reimbursed after my case settles.

❑ **I AM A SELF PAY PATIENT, I DON'T HAVE AN INSURANCE** and would like to…

Get a 30% discount by paying at the time of service.

4. Referral Info

How did you hear about us?

❑ Friend or Family: ❑ Brochure: Give details:
❑ Internet: ❑ Insurance/Directory:
❑ Advertisement: ❑ Other:

❑ Physician/Dentist/Chiropractor/Nurse:

Referring Physician/Person's Name _____

City _____ State _____

Phone # _____

Important Company Policies for a Successful Relationship

We strive to provide you the best personalized care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully, initial **all the boxes**, and indicate your agreement by signing this form (bottom).

Initial All Boxes

☐ **Late Policy "10-minutes"**
Being late by more than 10 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

☐ **24-Hour Advance Notice Fee**
If you wish to change or cancel an appointment we require a minimum ***24-hour advance notice***. Anything less will result in a ***$50 fee*** charged to your account. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.). We don't charge you the actual cost for that appointment but rather a mere ***$50 fee***. We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.

☐ **Copays are due upon arrival**
If you happen to forget your wallet or checkbook we may still be able to see you upon completion of an "Extension Request" form. This is a "promise-to-pay" form and carries a minimal fee that allows you to keep your appointment.

☐ **No-shows are bad**
If you fail to show for an appointment without notice all future appointments will be removed and a ***$50 fee*** assessed to your account. You may re-schedule appointments again on a "first come, first serve basis".

☐ **Cell phones must be shut OFF or silent.**
We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set to silent mode or turn off. Thank you.

☐ **Personal Valuables**
It is understood and agreed that Art of Healing PT is not responsible for loss or damage to any personal valuables or properties.

☐ **Financial Hardship**
If you are experiencing financial difficulties and are unable to afford the cost of our services we have a "Financial Hardship Form" which may be filled-out. If you qualify for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your (patient responsibility) portions of the bill. Ask the front desk person for assistance.

☐ **Important Notice from the Federal Government:**
"It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments . . . even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP's - Take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A(a)(5) of the Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA]. Exceptional cases do apply. Please see contact info for more information. Office of Inspector General, Department of Health and Human Services. Contact by by phone: 202 619-1343, by fax: 202 260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building, 333 Independence Avenue, S.W., Washington, D.C. 20201, Joel Schaer, Office of Counsel to the Inspector General, 202 619-0089."

I have read and agree to all the policies on this form. Signature: _____Date: _____

We look forward to building a successful relationship with you that lasts a lifetime!

Medical Screening Form

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In order to evaluate your condition fully, please be as accurate as possible. Thank you.

1. Where is your pain/problem? _____

2. In your opinion what caused your pain/or problem? _____

3. Approximately when did it start? _____ or _____/_____/_____

4. Have you ever had this pain/problem before? ☐ YES ☐ NO, For how long? _____

5. What makes your pain/ problem worse? _____

_____

6. What makes your pain/problem better? _____

_____

7. What are some potential obstacles to you getting better _____

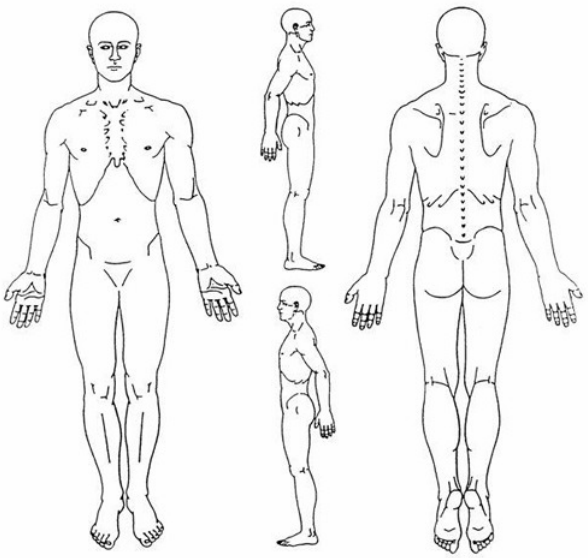
_____

8. How optimistic are you that you will get better? (**circle one below**)

Not at all Mildly optimistic Fairly Very optimistic Extremely

9. What are you expecting from your physical therapy program _____

FRONT **BACK**



10. On the scale below, **circle** your worst pain in the past couple of days:

Mild **Moderate** **Severe**

0……..1……..2……..3……..4……..5……..6……..7……..8……..9……..10

11. Are any of everyday activities affected ☐ YES ☐ NO
- If YES, describe below

12. List all past surgeries with dates below:

⇧Draw lines or crosses above where your symptoms are located ⍰

13. List all medical conditions you have (or were told you have)?

I understand that my candidacy for rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The doctor/therapist will determine whether or not I am a viable candidate for a rehabilitation program and that my activation into their system is not guaranteed.

Patient Name: _____Signature: _____Date: _____

Informed Consent and Policies Agreement

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Medical Necessity
All treatments must be justified and medically necessary in order for us to treat and bill your insurance. Some of the factors that determine whether or not treatment is medically necessary are:

1) Does your condition interfere with the quality of your life?
2) Does your condition interfere with your ability to perform work or daily activities?
3) Are you motivated and able to participate in your treatment program and follow home and self-care instruction?
4) Is there potential for your condition to improve and/or resolve? If not, is there potential for your function or ability to perform daily activities to improve through modified movement, assistive devices, etc.?
5) Are there specific goals set that are measureable and track-able?

If the above criteria are not met, you are welcomed to participate in our elective services such as 830laser, massage, fitness/exercise training, Pilates, etc. payable out-of-pocket by cash or check.

Cancel/No-show/Late
Please refer to the **"*Express Registration Form".***

Authorization for Release of Records
Assignment of Benefits (for insurance patients)
Please refer to the **"*Assignment of Benefits form".***

Results
The purpose of Physical Therapy is to maximize your body's own healing potential through natural means and promote your ability to perform daily, work, and leisure and sports activities through increased strength, flexibility, agility, and movement strategies. It is not possible to predict the results or outcomes of treatment. Sometimes benefits are realized immediately and sometimes it's more gradual over time.

Insurance Patients
It is your responsibility to know your benefit and insurance coverage for physical therapy services, including any maximums or exclusions. You are responsible for all charges whether paid by insurance or not. Any balances that exceed 30 days may incur fees and collection costs.

Medicare Patients
If you do NOT have supplemental insurance, you will be responsible for the twenty percent (20%) co-insurance portion not paid by Medicare as well as any deductible amounts not yet met. It is your responsibility to keep track of therapy cost totals for the purpose of not exceeding the Therapy Cap (unless your diagnosis is exempt from the Cap).

Minors and Parents
If patient is a minor (under 18 years of age), the parent or legal guardian is responsible for all charges and decisions made by the minor. We do not assume any liability for the minor while on premises or not, and it is the responsibility of the parent or guardian to supervise the minor before, during and after treatments.

Informed Consent
By signing below, the patient gives the therapist permission to the evaluation and treatment which may include palpation (manual examination) of body part(s) and close observation of body part(s), permission to the use of photographs for postural comparison. It is your right to accept or refuse any treatment offered. There are no guarantees made as to the results that may be obtained from our treatment(s). If you have any questions about your care, be sure to ask the therapist. It is up to patient/caretaker to inform the therapist/staff about any health problems or allergies patient may have. Patient/caretaker must also tell the therapist/staff about drugs or medications being taken as well as any medical conditions and/or surgeries.

Please discuss any questions or problems with the therapist before signing this statement of understanding and consent for care.

Patient Declaration
The therapist has explained to me the type of treatments ideal for my condition and the benefits of therapy, along with the risk of NOT receiving treatment. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent and policies form.

I have read and understand the foregoing explanation of rehabilitation/therapy care given to me. I hereby give my consent for the therapist to render treatments to me.

_____ _____ _____
Patient Signature Date Patient's Representative Signature/Date

_____
Relationship to Patient

HIPPA Notice Acknowledgement & Consent

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ACKNOWLEDGEMENT

I have received and read the Notice of Privacy Practices for the office **ART OF HEALING PT** and understand my rights contained in the notice.

CONSENT

I hereby give my consent for **ART OF HEALING PT** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). The Notice of Privacy Practices provided by the practice named above describes such uses and disclosures more completely.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **ART OF HEALING PT** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: **Krzysztof Cierniak, PT at 1500 E. Venice Ave., Suite 304 Venice, FL 34292**

With this consent, **ART OF HEALING PT** may:

- Call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including examination findings, test results, among others.
- Mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient billing statements as long as they are marked “Personal and Confidential.”
- Contact me by phone, mail, or email to participate in charitable events, patient appreciation days, educational seminars, health/wellness/fitness classes, or other marketing events to raise awareness, food donations, gifts, money, or promote pertinent products or services that might be useful to me.
- E-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient billing statements. I have the right to request that **ART OF HEALING PT** restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **ART OF HEALING PT** to use and disclose my PHI to carry out TPO and other approved uses as stated above.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **ART OF HEALING PT** may decline to provide treatment to me.

Signature of PATIENT or LEGAL GUARDIAN	Date
Print Name of Patient	Print Name of Legal Guardian, if applicable

Current Medications

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NAME: _____ DATE: _____

MEDICATIONS AND SUPPLEMENTS:

Medicare requires us to keep the most current list of your medications on our file. Please be as accurate as possible.

Please PRINT CLEARLY.

Name	Dose	Frequency	Route of Administration (by mouth, injections, cream, aerosol)

We would like to thank you for your cooperation.