New Patient Scan Checklist

*All documents must be completed, signed, dated by patient and front desk coordinator ***before*** scanning into Clinicient*

- € Scan ID
- € Scan front and back of Insurance Card

New Patient Paperwork

- € Intake Form from Clinicient with patient signature
- € Signed DPT consent to treat/policies
- € Completed and Signed Injury Questionnaire
- € Completed Medical History Form
- € Completed Medication List
- € Completed Pain Diagram
- € Signed Insurance Verification form
- € Completed Standardized test- scanned in separate category (label and date)

_____

Front desk coordinator name

Dear Patient,

Thank you for choosing *Doctors of Physical Therapy* for your rehabilitation needs. We are committed to providing quality care and service to our patients. We hope your experience in our facilities exceeds your expectations! The below document outlines some of our company policies. We highly recommend you take the time to read this document in its entirety and ask a member of our team to clarify any questions before signing the acknowledgment page.

Financial Policy

A part of our commitment of service to you is to educate ourselves on your insurance benefits. However, your insurance is a contract between you and/or your employer and the insurance company. We are not a party to that contract. As a courtesy to you, we will bill your insurance company, if we are provided correct and accurate information.

Your insurance carrier has stated to our staff that the information we received is not a guarantee of payment but considered a quote of benefits. Your insurance company will determine your benefits when they receive and process your claims. Once your claims are processed, an explanation of benefits will be communicated to both you and our facility.

You will receive, along with this document, an insurance verification form which outlines the specific benefit information we have received. If you feel the information provided is incorrect, please notify the front desk immediately.

Payment Policy

1. **Co-Payments**
   All co-payments are due at the time of service.
2. **Co-Insurance**
   An estimated co-insurance payment is requested at the time of service. We estimate each visit at $120.00/ visit to determine the co-insurance due at each visit. Please keep in mind that this is just an estimate and additional payment may be required in some cases.
   For example, if you have 20% co-insurance, we will request you pay $20.00 per visit.
3. **Deductibles**
   All charges will be billed to your primary insurance; any balance applied to your deductible will be billed to you.
4. **Monthly Statements**
   Any charges not paid at the time of service that are a patient's responsibility will be billed on a monthly basis to all patients. Payment for all statement balances is due within 30 days of the statement date. If you should have any questions or concerns regarding your statement, please contact our billing office at 800-974-4378 within 30 days of your statement date.

Please note: Additional payment options and payment plans may be available to those under financial hardship. Please contact our Billing office at 800-974-4378 for additional information.

Consent to Treat

I hereby grant my permission to the staff of *Doctors of Physical Therapy* to perform the procedures as prescribed by my physician. I have been informed of and understand the nature of the procedures that will be performed on me.

If I would become ill while undergoing treatment by *Doctors of Physical Therapy* staff, I give the staff permission to administer that treatment which they consider necessary to my well-being and only limited to physical therapy practice. My signature of mark below indicates that I understand and agree to the above-stated information.

Release of Medical Information and Authorization to Pay Insurance Benefits:

I authorize *Doctors of Physical Therapy* to release information from my medical record to my insurance carrier(s), or government agencies for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of benefits applicable to the services and pay all assigned insurance benefits directly to *Doctors of Physical Therapy* on my behalf.

I authorize the following recipients to have access to my medical records:

Name	Phone Number	Relationship

Medicare Certification:

I certify that the information given by me in applying for the payment under title XVIII of the Social Security Act is correct. I authorize *Doctors of Physical Therapy* to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediaries or carriers for the processing of claims for medical benefits. I request that payment of authorization benefits be made directly to *Doctors of Physical Therapy*, on my behalf.

Cancellation Policy:

In order to better serve our patients and ensure we are providing an exceptional experience; we require the following:

1. 24-hour notice of any scheduled appointment, including rescheduling or cancellation. **Failure to provide 24-hour notice may result in a $50.00 charge.**
2. Patients arriving more than 15 minutes after the starting time of their appointment may be asked to reschedule. Please provide us with advanced notice if you will be running late.
3. Patients that do not show up for their scheduled appointments and give no advanced notice may be subject to a $50.00 no show fee. Patients that do not show up for three consecutive treatments without notice will be automatically discharged.

Privacy Policy:

I acknowledge that I have received and fully understand the *Doctors of Physical Therapy* Notice of Privacy Practices. I also understand that a copy of the Privacy Practices is posted in all treatment locations, and an additional copy is available upon request.

Acknowledgement Page

I, _____, have read and understand the above *Doctors of Physical Therapy policies* including:

- Financial Policy
- Consent to Treat
- Release of Medical Information
- Medicare Certification (if applicable)
- Cancellation Policy
- Privacy Policy

With my signature below, I agree to the terms and conditions set forth by Doctors of Physical Therapy for payment, services, and treatment as provided in this document.

_____ _____

Patient Signature Date

_____

Printed Name

_____ _____

Guardian Signature if Patient is Under 18yrs.Old Date

_____

Printed Name

_____

Received By: Team Member Name

DPT
DOCTORS of PHYSICAL THERAPY

Injury Questionnaire

Patient Name _____ Date: _____

Date of Injury:_____

Was this injury accident related? Yes_____ No_____ circle one: AUTO WORK

If work related, please provide the following information:

Work Comp Insurance Company: _____

Case Manager Name and Phone Number: _____

Claim Number: _____

If auto related, in what state did this accident occur? _____

Do you have a copy of the auto accident report? Yes_____ No_____

Auto Insurance Company	Policy Number

Adjusters Name	Claim Number

Attorney Information (if applicable)

Attorney Name _____

Address _____

Phone Number _____

By signing this form I authorize the release of information requested by my insurance company for payment, I understand that I am financially responsible for any balance due, and I agree to comply to the terms and conditions as outlined on the Patient Policies form.

Patient Signature_____ Date_____

Patient printed name: _____

FDC Initials: _____

DPT DOCTORS of PHYSICAL THERAPY

Phone Number: (630) 434-0271 **Toll Free:** (800) 974-4378 **Fax:** (630)515-1536

Patient Medical History Form

Name: _____ DOB: _____

Occupation: _____ Height: _____

Leisure Activity: _____ Weight: _____

Please check the following conditions as they apply to you:

Condition	Yes	No	Explanation
Latex Allergy			
Other Allergies			
Heart Disease			
High Blood Pressure			
Diabetes			
TB			
Hepatitis			
Rheumatoid Arthritis			
Cancer			
Pacemaker			
Stroke			
Severe Dizziness			
Kidney Disorders			
Blood Disorders			
Thyroid Disease			
Other Autoimmune Illness			

1. What brings you here today? _____

2. When did you first experience this problem? _____

3. Have you been previously treated for this? _____

4. What makes the problem better or worse? _____

5. Are you currently taking any medication?
   Yes☐ No☐ ***If yes, please fill out Medication List***
6. Have you had any past or present surgical procedures?
   Yes☐ No☐ If yes, please list: _____
7. Are you currently pregnant?
   Yes☐ No☐ Pregnant in the last year? Yes☐ No☐
8. Do you Smoke?
   Yes☐ No☐ Packs per day: _____
9. Do you drink Alcohol?
   Yes☐ No☐ How often? _____
10. Are you currently receiving home health?
    Yes☐ No☐ If so, discharge date from home health? _____

Patient Signature: _____ Date: _____

DPT
DOCTORS of PHYSICAL THERAPY

MEDICATION LIST

Name:

DOB: Date:

MEDICATIONS (All Rx, OTC's, Supplements and Herbals)			
Medication Name	**Dose**	**Frequency**	**Route of Administration**

DPT
DOCTORS of PHYSICAL THERAPY

Name:_____

Patient Pain Evaluation Diagram

Date:_____

On the diagram below, please indicate where you have pain or other symptoms, and describe the type of pain or symptoms you are currently experiencing.

A = ACHE **B = BURNING** **N = NUMBNESS**
P = PINS & NEEDLES **S = STABBING** **O = OTHER (Please describe.)**