LoHi PHYSICAL THERAPY
CATALYST THERAPIES LLC

Physical Therapy • Occupational Therapy
Golf Fitness • Running Well® Seminars • Hand Therapy

303-458-9660 Phone 303-458-9661 Fax info@LoHiPT.com www.LoHIPT.com

Welcome and thank you for choosing LoHi PT. We will work along with you in our mission to see you reach your full potential. At the time of your initial visit, we will meet with you to obtain your contact information, health information, any specifics of your situation we need regarding billing and payment for services. Below is information and signatures we require before we can proceed with healthcare delivery. Please read, respond to or answer questions, initial and sign the forms as indicated.

Patient Name: _____ Date of Birth: _____

Please provide a record of your medication information to the best of your knowledge/ability. You may use the form below or provide your own list. Please sign as indicated below.

Prescription Medication

Name **Example Lipitor**	**Dose** **How Much?**	**Frequency** **When?**	**Route of Administration** **By mouth, injection, topical**

Over the Counter Medications, Vitamins or Herbal Supplements

Name **Example Vitamin D**	**Dose** **How Much?**	**Frequency** **When?**	**Route of Administration** **By mouth, injection, topical**

Please let your therapist know if any of your medications change during the course of your therapy.

Past and Current Medical History: mark any that apply to your situation.

__ Asthma/Allergies __ Thyroid Disorder __Aids/Hepatitis __Alcohol or Drug Addiction

__Stroke/Aneurysm __Back Pain __Cancer __Arthritis __Heart Disease/HBP

__Mental Illness __Diabetes/Kidney Disease __Lymphatic Disorder __Vision/Hearing Loss

Please provide a description of your health history below. You may want to clarify an item marked or provide information that is not listed. Please tell us about surgeries, any fractures, any falls or other traumas or injuries you may have had.

_____

_____

I attest to the accuracy of this list of medications, supplements, medical history:

Patient Signature: _____ Date: _____

Have you had Occupational or Physical Therapy in the past year? ____yes ____no If yes, tell us where and when.

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Patient Authorization and Guarantees. Please read each section and initial on the line. Sign below.

___ **PRIVACY POLICY:** I acknowledge I have been informed of the Privacy Policies for LoHi PT.
___ **CONSENTS AND DISCLOSURES:** I hereby voluntarily agree to physical therapy and occupational therapy assessment and treatment procedures which may be administered or performed on me by any practitioners at Catalyst Therapies, LLC dba LoHi Physical Therapy aka LoHiPT. I understand that the practice of physical therapy and occupational therapy is not an exact science and that assessment and treatment may involve risks. No guarantees have been made to me as to the results of my treatments. I understand that I am encouraged to ask questions and voice concerns about my treatment and that asking questions or voicing concerns will not compromise my treatment. I agree to inform the practitioners of any medical conditions which may have any effect on my treatment or on my safety. I understand that the therapists are not physicians and do not prescribe or administer medications or make medical diagnosis.
___ **VALUABLES:** I understand that LoHi PT is not responsible for valuables and personal property brought to the facility.
___ **ASSIGNMENTS OF INSURANCE BENEFITS:** I hereby assign payment directly to LoHi PT for any services that are reimbursable by any third party source and includes the basic benefits as identified in my health benefit plan in regards to outpatient OT/PT benefits. I understand I am financially responsible for any charges deemed as patient responsibility per my benefit plan. This includes copayments, coinsurance, deductible plans.
___ **FINANCIAL AGREEMENT:** For all items or services not covered by my insurance but agreed between myself and the practitioner that the item or service would benefit my outcome; I understand that I am financially responsible and agree to pay for services or supplies rendered by the above practitioners. Charges will be agreed upon in advance and paid upon completion of each session, unless other arrangements have been agreed upon. Upon request, the practitioners will provide documentation of services if I wish to submit for insurance or other reimbursement.
___**MEDICAL RELEASE OF INFORMATION:** I authorize the release and exchange of information with my referring/primary physician and with other professionals as authorized by me who are involved with my treatment. I authorize such organizations as third party payers or Medicare, release of medical information by phone or in writing, including reports of diagnosis, prognosis, recommendations, benefits payable and other data necessary to process claims for reimbursement of treatment rendered by LoHi PT.
___ **CANCELLATION POLICY:** I understand that I need to reschedule or cancel my appointment at least **24 hours** in advance. This allows time for other patients to be scheduled. I understand I will incur a **$30.00 charge** to my account if I fail to notify LoHi PT of schedule changes. __ **MISSED APPOINTMENTS:** We charge **$30.00** for failure to notify us. In case of emergency, please contact us and we will discuss unforeseeable and unavoidable events and grant exceptions as deemed pertinent and reasonable. (3 in a row) missed or cancelled appointments: We will work with you to schedule only one session at a time. If unable to keep your appointments, we reserve the right to help you find another provider.
__**BILLING:** We accept payments at time of service for all self-pay and for those with a straight copayment. For those who need claims processed to determine payment; we will bill you at no extra charge for the initial billing cycle after claims processing from your insurance. **Failure to pay after the initial cycle will result in a flat fee of $7.00 per month. Please be aware that invoices will be sent via email. If you would like to be billed via mail please let us know.**
I understand that all bills are due and payable at time of service or within one month of billing. I will be held responsible for any cost incurred regarding collection of payment for services rendered.

By signing below, I certify that I have read this agreement and/or it has been fully explained to me and I understand its contents. I certify I am the patient or a person duly authorized to execute this agreement and accept its terms
(if under age 18, print name of guardian or authorized person below and sign)

Printed Name:_____ **Signature:** _____

name of patient on this line if under age 18: _____

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Welcome and thank you for choosing LoHi PT.

If you have any questions, please ask and we will be happy to assist you. **Today's date: _____**

Name: Last_____ First_____ MI _____

Date of Birth: _____ Age: _____ ___male ___female

Tel: Home_____ Work _____ Cell _____

Address: _____ City_____ Zip code_____

Email: _____ **LoHi Newsletter? Yes No (circle one)**

Referring physician: _____ Primary physician _____

Ph#_____ Ph#_____

Referring diagnosis_____ _Date of onset _____ Date of surgery_____

Was there an accident? Auto Work Other Claim#_____

Name of adjustor or case manager: _____ Ph# _____

Responsible Party: If same as patient, same address and phone #, initial here _____

If different from patient, print name: _____ Ph#_____

Address: _____

Please state relationship to patient: _____

Name of emergency contact: _____ Ph# _____

* for health plan and ID, please provide us with your card to copy and you will not need to fill out Plan & ID

* Health Insurance Plan: _____ ID# _____

Do you have secondary insurance? _____ Please List: _____