CUTTING EDGE
PHYSICAL THERAPY

Patient Information:

Name:_____ Social Security #: _____ Sex: Male

Address: _____City: _____State: _____Zip: _____

Home Phone: _____ Mobile Phone: _____

Emergency Contact/Relationship: _____ Alternate Phone: _____

Birth date: _____ Age: _____ Marital Status: Single

Email address:_____

Employer: _____Full time/Part time Referring Physician:_____

Primary Care Physician: _____

How did you hear about us? Referring Physician

If a minor, name of responsible party: _____

☐ **Bill Me Personally**

☐ **Workers Compensation Claim: State: _____ ID Number:_____**

☐ **Primary Insurance Information:**

Policy Holders Name: _____ Relationship to patient: _____

Birth date of insured: _____Insured Social Security#_____Employer:_____

Insurance Name: _____ Insurance Phone:_____

Insurance Address:_____

Policy #:_____ Group #:_____

☐ **Secondary Insurance Information:**

Policy Holders Name: _____ Relationship to patient: _____

Birth date of insured: _____Insured Social Security#_____ Employer: _____

Insurance Name: _____ Insurance Phone: _____

Insurance Address: _____

Policy #: _____ Group #: _____

Accident Information:

Type: Auto Date: _____ How and where did the accident occur? _____

_____

Signature of patient or legal guardian_____ Date:_____

PATIENT PAYMENT AND INFORMATION AUTHORIZATION AGREEMENT

PLEASE READ CAREFULLY BEFORE SIGNING

1. I GIVE MY CONSENT TO BE EVALUATED AND TREATED BY CUTTING EDGE PHYSICAL THERAPY, LLC
2. I HAVE READ AND UNDERSTAND THE CONTENTS OF THE NOTICE OF PRIVACY PRACTICES.
3. I UNDERSTAND THAT I AM RESPONSIBLE FOR MY BILL.
4. I UNDERSTAND THAT COPAYS WILL BE EXPECTED AT THE TIME OF SERVICE.
5. I AGREE TO PAY REASONABLE FINANCE CHARGES, ATTORNEY FEES AND ANY ADDITIONAL FEES IF MY ACCOUNT BECOMES DELINQUENT AND IF IT BECOMES NECESSARY TO TURN MY ACCOUNT OVER TO A COLLECTION AGENCY.
6. IT IS THE PATIENT'S RESPONSBILITY TO PROVIDE US WITH COMPLETE AND ACCURATE INSURANCE INFORMATION IN ORDER FOR US TO BILL. THE PATIENT MUST ALSO PROVIDE ANY OTHER SPECIAL REQUIREMENTS BY THE INSURANCE COMPANY. THE REQUIREMENTS MAY INCLUDE, BUT ARE NOT LIMITED TO, REFERRALS FROM PCP, ACCIDENT INFORMATION, OR PRE-AUTHORIZATION FROM ORDERING DOCTOR. I UNDERSTAND THAT I AM RESPONSIBLE FOR CHECKING MY OWN INSURANCE BENEFITS BEFORE RECEIVING TREATMENT. _____INTIALS
7. WE WILL BILL YOUR INSURANCE COMPANY AS A COURTESY. WE ENCOURAGE YOU TO FOLLOW UP WITH YOUR INSURANCE COMPANY ON ALL OF YOUR CLAIMS TO ENSURE TIMELY PROCESSING AND AVOID ANY OTHER DELAYS.
8. **CANCELLATIONS NOT MADE 24 HOURS PRIOR TO APPOINTMENT ARE SUBJECT TO A $40.00 FEE OR NO SHOW, WHICH INCLUDES CANCELLING WITHIN 2 HOURS OF YOUR SCHEDULED TIME WILL BE SUBJECT TO A $100.00 CHARGE.**

REFERRAL (PRESCRIPTION):

A physician's referral for physical therapy treatment is required by some insurance companies for reimbursement. Physical therapy services can be rendered without a referral but cash payment will be required if your insurance carrier does not reimburse without a referral.

MEDICARE / WORKERS' COMPENSATION PATIENTS:

Medicare and Workers' Compensation will not pay for a physical therapy visit unless the patient has seen their referring physician within 30 days of that visit. Please let us know when you see your doctor. If Medicare or Workers' Compensation does not pay for your physical therapy because you have not seen the doctor within 30 days of the physical therapy visit, the charges for service will be your responsibility. **If Workers' Compensation claims are not being paid due to objections then patient's private insurance will be billed, or the patient directly.**

LIEN PATIENTS:

If you are a patient that is on a lien, patient must see **their doctor every 8 weeks**, as well as **stay in constant contact with their attorney**, so they know the progress of the patient's rehabilitation. **The patient must also provide medical insurance information, in the case that the lien does not pay due to objections. In that case, the patient's private insurance will be billed, or the patient directly.**

SECONDARY INSURANCE BILLING:

We will bill secondary insurance once the primary carrier has responded. If the primary insurance has made payment directly to the patient we must have a copy of the Explanation of Benefits in order to bill the secondary carrier. In the event that the primary carrier has not responded to our claim, we will not take action to collect from the secondary carrier in the patient's behalf.

In the event that industrial or auto insurance exhausts or refuses to pay I authorize Cutting Edge Physical Therapy to bill my personal health insurance, or the patient directly.

PATIENT BALANCES NOT PAID WITHIN 30 DAYS:

We allow 30 days for patients to pay their patient balance in full. All accounts not paid by 30 days will be assessed a late fee of 1.5% interest on patients balances. Accounts not paid in full by 90 days will be assessed a 50% handling fee to the current balance and then turned over to a collection agency. The account balance is the responsibility of the patient or responsible party whether the insurance pays or not.

PATIENTS WITHOUT INSURANCE:

If the patient does not have insurance, payment for services rendered will be expected at the time of service.

SIGNATURE: _____ DATE: _____

OFFICE REP.: _____ DATE: _____

CUTTING EDGE
PHYSICAL THERAPY

UPDATE to **PATIENT PAYMENT AND INFORMATION AUTHORIZATION AGREEMENT**
PLEASE READ CAREFULLY BEFORE SIGNING.

- CANCELLATIONS NOT MADE 24 HOURS PRIOR TO APPOINTMENT ARE SUBJECT TO A $40.00 FEE OR NO SHOW, WHICH INCLUDES CANCELLING WITHIN 2 HOURS OF YOUR SCHEDULED TIME WILL BE SUBJECT TO A **$100.00 CHARGE**. CHANGE IN RATES MAY BE APPLIED AT ANY TIME.

- IF A PATIENT'S **INSURANCE CHANGES AT ANY TIME**, THE PATIENT IS RESPONSIBLE FOR INFORMING AND PROVIDING NEW INSURANCE INFORMATION TO OUR OFFICE OR THE PATIENT WILL BE RESPONSIBLE FOR ANY BALANCE THAT IS ACCRUED TO THEIR ACCOUNT. **NO EXCEPTIONS!**

- PATIENTS MUST **PROVIDE PROOF OF INSURANCE AT TIME OF SERVICE** OR THEY WILL BE RESPONSIBLE FOR ANY BALANCE THAT IS ACCRUED TO THEIR ACCOUNT OR MAY NOT BE TREATED. SUBJECT TO THERAPIST APPROVAL.

- IF A PATIENT IS THE AGE OF 18 OR OVER, THEY MUST SIGN A **"RELEASE AUTHORIZATION FORM"** IF THEY WISH FOR ANYONE TO HAVE ANY ACCESS TO THEIR MEDICAL RECORDS, BILLING RECORDS, ETC.

- WE ALLOW 30 DAYS FOR PATIENTS TO PAY THEIR BALANCE IN FULL. ALL ACCOUNTS **NOT PAID BY 30 DAY** WILL BE ASSESSED A **LATE FEE OF 1.5% ON PATIENT BALANCES**.

PLEASE CAREFULLY READ THE UPDATES TO THE PAPERWORK ABOVE AND SIGN BELOW.

SIGNATURE: _____ DATE: _____

CUTTING EDGE
PHYSICAL THERAPY

NOTICE

In order to make physical therapy services affordable for our valued patients, Cutting Edge Physical Therapy offers a discounted self-pay rate of $150.00 per initial evaluation and $125.00 per following dates of service, ***which must be paid prior to receiving treatment***. If you choose this option, your insurance will not be billed for your treatment.

If you choose to have your insurance billed for your treatment, your insurance may leave you responsible for an amount greater than our discounted self-pay rate. Some insurance plans will apply charges for physical therapy services to a patient's deductible, co-pay, or co-insurance. ***Self-pay discounts are not available after a patient chooses to have Cutting Edge Physical Therapy submit claims to insurance.***

Individual insurance plans vary greatly; therefore, it is strongly recommended that you discuss your particular plan benefits with your insurance carrier. Our office will contact your insurance to verify that you have active coverage; however, we are unable to provide patients with specific plan details and costs.

I, _____ have been notified that it is my responsibility to know and understand my insurance plan details, and discuss those details with my insurance carrier if I have any questions regarding my plan benefits.

_____ _____

Printed name of patient or legal guardian **Date**

_____

Signature of patient or legal guardian

I guarantee payment of all physical therapy charges for treatment provided to the above named patient to Cutting Edge Physical Therapy. I understand that I am financially responsible for all charges including but not limited to all co-payments, deductibles, and expenses not covered or paid by insurance.

CUTTING EDGE
PHYSICAL THERAPY

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, leave it blank and your therapist will assist you. Thank you!

Name: _____ Date: _____ Age: _____
Occupation: _____

Is this an injury?
Worker's Compensation injury ☐ Yes ☐ No
MVA (Auto Accident) ☐ Yes ☐ No

Are you working with a lawyer for this injury/condition?
☐ Yes ☐ No

Are you currently: (Please Check One)
☐ a. Working at your usual job without restrictions
☐ b. Working at your usual job with restrictions
☐ c. Retired/Unemployed
☐ d. Unable to work because of other medical reasons
☐ e. Unable to work because of your condition

When did your current condition begin?
Month _____Day_____ Year_____
Surgery? ☐ Yes ☐ No Date:_____

What originally caused your current symptoms? (Please Check One)
☐ a. Not sure of the cause
☐ b. Fall/Slip
☐ c. Motor Vehicle Accident
☐ d. Bend/twist
☐ e. Cough/Sneeze
☐ f. Lifting
☐ g. Yard Work
☐ h. Athletic Activity
☐ i. Shoveling Snow
☐ J. Other_____

PAIN INTENSITY: 0= No Pain 10= Emergency Room
At its Best 0-10 _____
At its Worst 0-10 _____
Now 0-10_____

ALLERGIES: List any medication(s) you are allergic to: _____
Are you latex sensitive? ☐ Yes ☐ No
List any other allergies we should know about: _____
Have you declared the Advanced Clinical Directive of Do Not Resuscitate? ☐ Yes ☐ No

Please check any of the following whose care you are under:
☐ Medical Doctor (MD)
☐ Psychiatrist/psychologist
☐ Osteopath (DO)
☐ Dentist
☐ Chiropractor
☐ Other_____

Have you had:
☐ X-rays
☐ MRI
☐ CT Scan
☐ Other Studies

Have YOU ever been diagnosed as having any of the following conditions?

Cancer	◯ Yes ◯ No	Kind_____	Heart Problems	◯ Yes ◯ No
High Blood Pressure	◯ Yes ◯ No		Circulation Problems	◯ Yes ◯ No
Asthma	◯ Yes ◯ No		Emphysema/Bronchitis	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No		Thyroid Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No		Multiple Sclerosis	◯ Yes ◯ No
Rheumatoid Arthritis	◯ Yes ◯ No		Depression	◯ Yes ◯ No
Other Arthritis Conditions	◯ Yes ◯ No	Kind_____	Hepatitis	◯ Yes ◯ No
HIV/AIDS	◯ Yes ◯ No		Tuberculosis	◯ Yes ◯ No
Stroke	◯ Yes ◯ No		Kidney Disease	◯ Yes ◯ No

Anemia ___Yes ___No
Epilepsy ___Yes ___No
Osteoporosis ___Yes ___No
Other_____

Has ANYONE IN YOUR IMMEDIATE FAMILY (parents, brothers, sisters) ever been treated for any of the following?

Diabetes ___Yes ___No
Tuberculosis ___Yes ___No
Heart Disease ___Yes ___No
High Blood Pressure ___Yes ___No
Stroke ___Yes ___No
Kidney Disease ___Yes ___No
Chemical Dependency ___Yes ___No
Cancer ___Yes ___No
Arthritis ___Yes ___No
Anemia ___Yes ___No
Headaches ___Yes ___No
Epilepsy ___Yes ___No
Mental Illness ___Yes ___No

Have you recently noted the following?

Weight Gain/Loss ___Yes ___No
Fatigue ___Yes ___No
Fever/Chills/Sweats ___Yes ___No
Nausea/Vomiting ___Yes ___No
Weakness ___Yes ___No
Numbness or Tingling ___Yes ___No

FOR WOMEN: Are you currently pregnant or think you might be pregnant? ___Yes ___No

If you have been under the care of a physician during the past three months, please describe for what reason (illness, medical condition, physical, etc.:_____
_____

Please list any injuries, surgeries, or other conditions you have treated or hospitalized for, including the approximate date, side and reason for the treatment:

DATE REASON FOR INJURY/SURGERY/HOSPITALIZATION

_____ _____
_____ _____
_____ _____
_____ _____

Please list any PRESCRIPTION medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

_____ 4. _____
_____ 5. _____
_____ 6. _____

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

Tylenol ___Yes ___No
Advil/Motrin/Ibuprofen ___Yes ___No
Decongestants ___Yes ___No
Antacid ___Yes ___No
Other_____
Aspirin ___Yes ___No
Laxatives ___Yes ___No
Antihistamines ___Yes ___No
Vitamins/Minerals ___Yes ___No

How often do you:	Daily	Frequently (1-3x/wk)	Occasionally 1-3x/mos)	Never
Drink caffeinated drinks/coffee	☐	☐	☐	☐
Smoke cigarettes	☐	☐	☐	☐
Drink alcohol	☐	☐	☐	☐
Use illegal substances	☐	☐	☐	☐

_____ _____
Patient Signature Date Therapist Signature Date

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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPPA" provides penalties for covered entitles that misuse personal health information.

As required, we have prepared this explanation of how we are required to maintain this privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: Treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written re quest, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer.

The right to request restrictions on certain uses and disclosures of protected health information, including those related disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

The right to inspect and copy your protected health information.

The right to amend your protected health information.

The right to receive an accounting of disclosures of protected health information. The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of (mm/dd/yyyy)_____ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:

Cutting Edge Physical Therapy
308 East 4500 South, Suite 280
Murray, Utah 84107
Phone: 801.685.9212 Fax: 801.685.9195
ceptut@gmail.com

CUTTING EDGE
PHYSICAL THERAPY

Cutting Edge Physical Therapy
308 East 4500 South, Suite 280
Murray, Utah 84107
801-685-9212

ACKNOWLEDGMENT
NOTICE OF PRIVACY PRACTICES

I Hereby acknowledge that a copy of the Cutting Edge Physical Therapy Notice of Privacy Practices was provided to me. I further acknowledge and understand that if I have any questions about the Cutting Edge Physical Therapy privacy practices or my rights with regard to my personal health information, I may contact the appropriate person for further information as set forth in the Notice.

_____ _____
Name of Patient (and Patient's Representative, if one) Patient Account #

_____ _____
Signature of Patient (or Patient's Representative) Date

Staff Use Only:

To Be Used By Office Staff Only If Patient Written Acknowledgement Is Not Obtained.

DOCUMENTATION SUPPORTING GOOD FAITH EFFORT TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name:_____ Patient acct #_____

I hereby certify that on __/__/__(MM/DD/YR), I made a good faith effort to obtain the above patient's written acknowledge of receipt of the Cutting Edge Physical Therapy Notice of Privacy Practices, but I was unable to do for the following reason(s).

_____
_____
_____

_____ _____
Name of Staff Representative (Print) Signature of Staff Representative Date