CUTTING EDGE
PHYSICAL THERAPY

To help us provide you with a complete and thorough evaluation, please provide the following information to the best of your ability. If you do not understand a question, leave it blank and your therapist will assist you. Thank you.

Name:_____ Age:_____ Date of Birth:_____

Nickname or Preferred Name:_____

Gender:_____ Preferred Pronouns (eg: she/her/hers): _____

Social Security #: _____

Primary Phone:_____ Alternate Phone: _____

Email:_____

Address: _____ City: _____ State: _____ Zip:_____

Occupation:_____ Full Time / Part Time

Emergency Contact/Relationship: _____

If a minor, name of responsible party: _____

Who referred you to physical therapy? _____

Do you have a primary care physician? Yes / No Name:_____

Please indicate any other medical professionals whose care you are under for this *or any other* condition.

_____

_____

_____

How did you hear about Cutting Edge Physical Therapy?:

Referring Dr. / Primary Dr. / Other (please specify)_____

- Is this injury related to Motor Vehicle Accident Yes / No Date:_____
- Is this a Worker's Compensation injury? Yes / No Date:_____
  Employer:_____
  Workers Compensation Claim: State:_____ ID Number:_____
- Are you working with a lawyer for this injury/condition? Yes / No
- Are you currently pregnant? Yes / No If so, how many weeks?_____

Are you currently: (check one)

_____ Working at your usual job without restrictions
_____ Working at your usual job with restrictions
_____ Unable to work because of this injury/condition
_____ Unable to work because of another medical condition
_____ Retired

Have you recently noticed any of the following:

| | | |
|---|---|---|
| Weight Gain/Loss | ____ Yes | ____ No |
| Fatigue | ____ Yes | ____ No |
| Fever/Chills/Sweats | ____ Yes | ____ No |
| Nausea/Vomiting | ____ Yes | ____ No |
| Weakness | ____ Yes | ____ No |
| Numbness/Tingling | ____ Yes | ____ No |

Signature of patient or legal guardian:_____ Date:_____

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Please provide the following information *in reference to the issue that is bringing you in today*.

What is your primary complaint? _____

What are your goals for therapy?_____

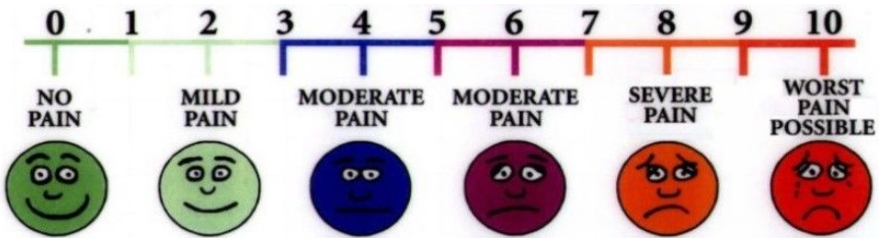
When did your condition begin? _____

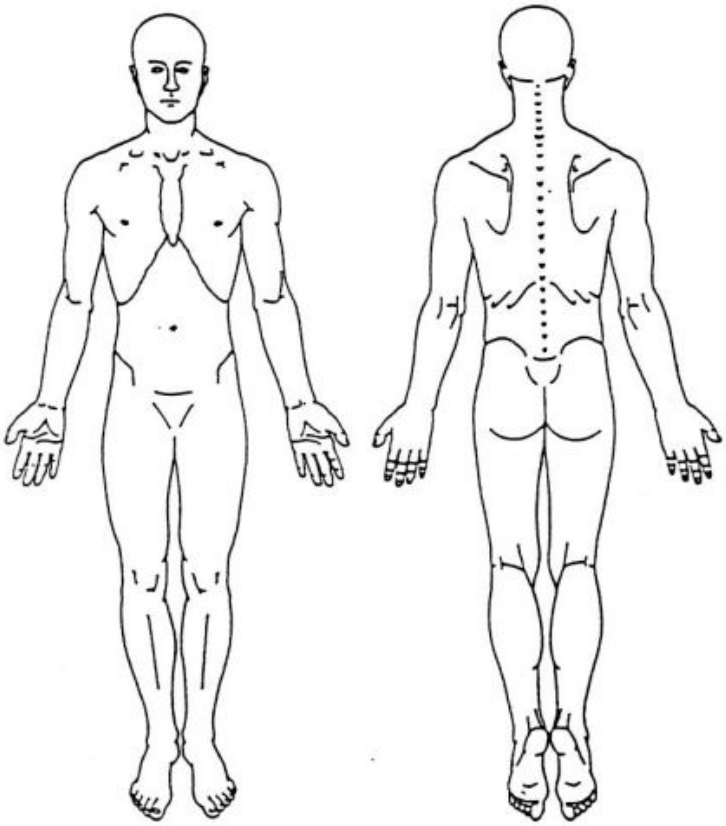
Have you had any imaging done regarding this condition?

_____X-ray _____MRI _____CT Scan _____Other: _____

Have you had surgery for this condition? ____ Yes ____ No Date:_____

Please indicate the severity of your symptoms



Please mark your area of pain on the drawings to the right.

Please describe your symptoms (check all that apply):

____ Aching ____ Burning
____ Stabbing ____ Numbness
____ Tingling ____ Throbbing
____ Other: _____

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## Past Medical History

Please indicate whether you are currently or have previously been diagnosed with any of the following:

| | Now | Past |
|---|---|---|
| Autoimmune Disorders | ____ | ____ |
| Arthritic Conditions | ____ | ____ |
| Kind:_____ | | |
| Asthma | ____ | ____ |
| Bronchitis or Emphysema | ____ | ____ |
| Blood Clot or Emboli | ____ | ____ |
| Bowel or Bladder issues | ____ | ____ |
| Cancer | ____ | ____ |
| Kind:_____ | | |
| Celiac | ____ | ____ |
| Diabetes | ____ | ____ |
| Dizziness or Fainting | ____ | ____ |
| Epilepsy | ____ | ____ |

| | Now | Past |
|---|---|---|
| Heart Disease | ____ | ____ |
| High Blood Pressure | ____ | ____ |
| Heart Attack or Surgery | ____ | ____ |
| Infectious Diseases | ____ | ____ |
| Kind:_____ | | |
| Kidney Disease | ____ | ____ |
| Lupus | ____ | ____ |
| Multiple Sclerosis | ____ | ____ |
| Psychological/emotional issues | ____ | ____ |
| Kind:_____ | | |
| Shortness of Breath/Chest Pain | ____ | ____ |
| Stroke | ____ | ____ |
| Thyroid Problems | ____ | ____ |

Other (please list): _____

_____

Please list any medications/supplements you are currently taking, including prescriptions, over-the-counter medications, injections, or skin patches (if you would like us to photocopy a pre-written list, please let us know):

_____

_____

Are you latex sensitive? ____ Yes ____ No

Do you have any allergies to medications? ____ Yes ____ No Kind: _____

Do you have a pacemaker? ____ Yes ____ No

Do you have any metal surgical implants? ____ Yes ____ No Kind: _____

Please list any prior surgeries and their dates:

| Date | Surgical Procedure |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Is there any family medical history you feel we should know?_____

_____

_____

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## PATIENT AUTHORIZATION FOR TREATMENT AND PAYMENT INFORMATION
## PLEASE READ CAREFULLY BEFORE SIGNING

- I give my consent to be evaluated and treated by Cutting Edge Physical Therapy, LLC
- **Cancellations not made 24 hours prior to appointment are subject to a $40.00 fee; A no-show or cancellation within 2 hours of your scheduled time will be subject to a $100.00 charge.** _____ (initials)
- I understand that I am responsible for checking my own insurance benefits before receiving treatment. And that I am ultimately responsible for my bill if insurance or other entity denies payment. _____ (initials)
- If I so choose, Cutting Edge Physical Therapy, LLC will bill my insurance 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.
- It is my responsibility to provide Cutting Edge Physical Therapy, LLC with complete and accurate insurance information in order for us to bill, as well as any other special requirements by the insurance company.
- If my insurance changes at any time, it is my responsibility to inform Cutting Edge Physical Therapy, LLC and provide new insurance information, or I will be responsible for my balance.
- I understand that **copays will be expected at the time of service**.
- 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.
- If a patient is 18 years of age or older, they must sign a "Release Authorization Form" if they wish for anyone to have any access to their medical records, billing records, or other information

**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.

**Workers' Compensation:**
If Workers' Compensation denies coverage of your physical therapy treatments for any reason, you may determine whether you would like us to bill your private insurance or bill you directly for services.

**Lien Patients:**
If you are a patient that is on a lien, please stay in contact with your attorney so that they know the progress of your rehabilitation. The patient must also provide medical insurance information, in the case that the lien does not pay due to objections. In that case, you may determine whether you would like us to bill your private insurance or bill you directly for services.

**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 on the patient's behalf. In the event that industrial or auto insurance exhausts or refuses to pay, the patient will be given the opportunity to decide whether to authorize Cutting Edge Physical Therapy to bill their personal health insurance, or bill them 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 the balance. 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: _____

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## Payment Information

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 each 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 their 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.

**How would you like to handle your payment for treatments?**

❑ Bill Me Personally

❑ Workers' Compensation (information provided previously)

❑ Motor Vehicle Accident (please provide insurance information upon request)

❑ Primary Insurance (Please provide information if known)

Policy Holder's Name:_____ Relationship to patient:_____
Birth Date of Policy Holder:_____ SSN of Policy Holder:_____ Employer:_____
Insurance Name:_____ Insurance Phone: _____
Insurance Address:_____
Policy Number:_____ Group Number:_____

❑ Secondary Insurance (Please provide insurance information upon request)

**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 by not limited to all co-payments, deductibles, and expenses not covered or paid by insurance.**

_____ _____
Printed name of patient or legal guardian Date

_____
Signature of patient or legal guardian

CUTTING EDGE
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Cutting Edge Physical Therapy
308
4500 South, Suite 280
Murray, UT 84107
801-685-9212

**ACKNOWLEDGEMENT**
**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 Representative when applicable) Patient Account Number

_____ _____
Signature of Patient (or Patient Representative) Date

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**Staff Use Only:**

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

DOCUMENTATIONS 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/yyyy) _____ I made a good faith effort to obtain the above patient's written acknowledgement of receipt of the Cutting Edge Physical Therapy Notice of Privacy Practices, but I was unable to do so for the following reason(s).
_____

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