MEDICAL HISTORY FORM

CORE BALANCE
Physical & Vestibular Therapy

Name: _____

Date of Onset: _____

Occupation: _____ Recreational Activities: _____

Allergies: Adhesive Latex Other: _____

Pregnant Y N Use of tobacco products Y N

Do you have any known precautions or restrictions: _____

Check if you have or have had any of the following.

(Add remarks if applicable)

Diabetes	Blood Pressure Problems: _____
Pacemaker	Heart Problems: _____
Stroke / CVA / TIA	Infectious Diseases: _____
Asthma	Kidney Problems: _____
Headaches	Thyroid Problems: _____
Migraines	Bowel / Bladder Problems: _____
Memory Problems	Cancer: _____
Communication Problems	Metal Implants: _____
Seizures / Epilepsy	Joint Replacement: _____
COPD	Spine Surgery: _____
Osteoarthritis	General Surgery: _____
Rheumatoid Arthritis	Fractures: _____
Osteoporosis	Dislocations: _____

Is there any other information regarding your past medical history that we should know about?

_____

_____

_____

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CORE BALANCE PHYSICAL & VESTIBULAR THERAPY

MEDICAL HISTORY FORM p. 2

Please list all medications you are currently taking, including dosage and frequency.

Name of Medication	Dosage/Frequency	Notes (i.e.-as needed)

List a provider other than your referring provider to whom you would like your physical therapy notes sent:

Doctor's Name: _____

Location:_____

Phone:_____ Fax:_____

Patient Signature: _____ **Today's Date:** _____

Welcome to CORE BALANCE Physical & Vestibular Therapy

Consent for Treatment

I acknowledge that the information I have provided is accurate and complete. I agree to have a licensed Physical Therapist perform an evaluation, establish a treatment plan, and render appropriate treatment. I also authorize the release of any pertinent information regarding my case to any insurance company, adjuster, physician, dentist, or podiatrist, or attorney involved in this case.

Privacy

In compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and our Notice of Privacy Practices, CORE BALANCE will not disclose your protected health information (PHI) without your explicit authorization, except as permitted by law for the purposes of payment, treatment, and health care operations. CORE BALANCE will limit the use and disclosure of PHI to the minimum necessary to accomplish the intended purpose and only disclose your appointment information, such as reminders or cancelations, on an answering machine, voice mail, text message or e-mail, unless you inform us otherwise. I acknowledge that I have received or have been offered a copy of the HIPAA Privacy Notice.

Attendance and Cancelation Policy

Therapy at CORE BALANCE means exceptional, personal, one-on-one physical therapy that is designed specifically for YOU to meet your goals. To receive the full benefits of treatment, it is important that you attend each of your sessions and arrive on time. The outcome of your treatment is important, and success depends on consistency of your attendance. Your appointments are reserved at a specific time for you. Failure to keep your appointments is a lost opportunity to help you. Please call as soon as possible so we can reschedule your appointment. Because we give you one full hour with a therapist, we require at least one full (24 hour) business day notice to avoid a cancelation charge.

A fee of $40 may be charged for an appointment cancelled with less than one full business day (24 hours) or for a no-show/missed appointment. If you are ill, please call to discuss and we will likely wave this fee. This fee must be paid before the start of your next appointment. This fee is not billable or payable by insurance. After three (3) late cancels or no-show appointments, CORE BALANCE, has the right to discharge you from therapy back to your referring physician. We understand that emergencies do occur, and each situation is unique and will take this into consideration.

By signing this form, I authorized CORE BALANCE, to initiate and deliver treatment of therapy services. I also have read and understand the attendance and privacy policies.

Patient Name	Signature of Patient or Patient Representative	Date

PATIENT FINANCIAL POLICY

This is an agreement between CORE BALANCE, PLC (creditor) and the Patient (debtor) named on this form. In this agreement the words, "you", "your", and "yours" mean the patient. The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we", "us", and "our" refer to CORE BALANCE. By executing this agreement, you agree to pay for all services and supplies that are received.

Billing information

As a courtesy to our patients, we will bill your insurance carrier, it is your responsibility to provide us with correct information including insurance, responsible party, date of injury, type of accident, policy and/or group numbers, etc. If the information changes, it is your responsibility to update it within a timely manner. If you supply us with incorrect information, the balance of the account will be entirely patient responsibility. We will not be responsible for rebilling, appealing, or other dealings with newly provided insurance carrier. We accept cash, personal checks, VISA, MasterCard, and Discover. There is a $40 fee for each returned check from your bank.

If possible, we will verify insurance benefits and eligibility prior to the first appointment as a courtesy. The ultimate responsibility is with the patient. As a courtesy to you, we will bill your primary, secondary, and tertiary insurance; however, if our office has not received payment after 90 days, the balance will become patient responsibility unless other arrangements are made with us.

Required Payments

Any co-payments or co-insurance required by an insurance carrier must be paid at the time of service. We have the right to cancel your privilege to make charges against your account at any time and require that visits must be paid at the time of service. If you have a balance on your account, we will send you a monthly statement. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued and is considered past due if not paid by the end of the month.

Contracted Insurance

If we are contracted with your insurance carrier, we must follow our contract and their requirements. If you have a co-pay, deductible, or co-insurance, you must pay that at the time of service. As contracted providers with your insurance carrier we agree to accept the allowable amount (usual and customary) established by your insurance carrier. Although we may estimate what your insurance carrier may pay and the patient responsibility portion, it is the insurance carrier that makes the final determination of payment and eligibility.

Non-Contracted Insurance

Insurance is a contract between you and your insurance carrier. It is the patient's responsibility to verify if our office is a contracted or non-contracted provider. We will still bill your insurance carrier as a non-contracted provider. There is no adjustment or write-off for the difference between what we charge and what the insurance allows. You agree to pay any portion of the charges not covered by your insurance.

Waiver of Confidentiality

If this account is submitted to an attorney or collection agency, if we litigate in court, or if your past due status is reported to a credit reporting agency the fact that you received treatment at our office may become a matter of public record.

Authorizations/Referrals

If your insurance carrier requires a referral or authorization, you are responsible for obtaining it or ensuring that it is being sought by Core Balance on your behalf. As a courtesy, we will seek authorization if we are made aware of the requirement, but ultimately it is the patient's responsibility to ensure it is done. All denied insurance claims due to unattained prior authorization will be the sole financial responsibility of the patient. Failure to obtain this referral or authorization may result in reduced or no payment from your insurance company. You are encouraged to contact your insurance company to verify your PT benefits and to communicate all known authorization requirements to Core Balance.

Worker's Compensation

If your claim is in deferred status, we will ask for private medical insurance to bill if your claim is denied. We require approval/authorization by worker's carrier prior to your initial visit. If your claim is denied and you do not have private medical insurance, you will be responsible for payment in full. If your claim is in litigation, we do require verification of this from your attorney and/or worker's compensation carrier, and may require upfront payment until your litigation is settled.

Personal Injury/Motor Vehicle Accidents

If you are being treated as part of a personal injury lawsuit or claim, we may require verification from your attorney. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred in a personal injury case. If you have Personal Injury Protection (PIP) through your motor vehicle insurance, we will bill them as primary insurance and will bill your private health insurance when your PIP benefits are used up.

Benefit Assignment

You assign all medical benefits to us. This includes health, Medicare, auto insurance, and worker's compensation or other insurance plans. You also authorized us to release all information necessary (including photocopies of medical records) to secure payment. You agree that if insurance pays you directly, this monetary amount is actually owed us and is your responsibility to provide us payment.

Finance Charge

A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was paid by your insurance company or due by you. The FINANCE CHARGE will be computed at the rate of one percent (1%) per month or an ANNUAL PERCENTAGE RATE of twelve (12%). The finance charge on your account is computed by applying the period rate (1%) to the "past due balance" of your account. The "past due" balance of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. You understand that finance charges are not billable or payable by insurance.

Past Due Accounts

If your account balance becomes past due, we may need to take necessary steps to collect this debt. This may include contracting the person listed as the Emergency Contact on your patient data sheet. If we refer your account to a collection agency, you agree to pay all the collection costs which are incurred. We will add a surcharge of 30% to your balance if your account is turned over to an outside collections agency. If we refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs.

By signing below, I accept the patient financial policies listed above.

Patient Name (print)_____

Signature_____Date_____

Core Balance

Telemedicine Consent Form

Due to unprecedented times, I understand that my health care provider may wish for me to engage in a telemedicine consultation using Doxy.me. This consent is in the event that the patient should require Telemedicine consultation now or in the future.

1. My health care provider has explained to me how the Doxy.me video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
2. I understand that if others are present during the consultation other than my health care provider, they will maintain confidentiality of the information obtained. I further understand that they will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following:
    a. Omit specific details of my medical history/physical examination that are personally sensitive to me
    b. Ask non-medical personnel to leave the telemedicine examination room
    c. To terminate the consultation at any time
3. I have had the alternative to a telemedicine consultation explained to me, and in choosing to participate in a doxy.me telemedicine consultation.
4. In an emergency, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner, and that the specialist's responsibility will conclude upon the termination of the Doxy.me video conference connection.
5. I have had a direct conversation with my health care provider during which I had the opportunity to ask questions regarding this procedure. My questions have been answered, and the risks, benefits, and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify

- that I have read or had this form read to me/explained to me
- that I fully understand its contents including the risks and benefits of the procedure(s).
- that I have been given ample opportunity to ask questions, and that any questions have been answered to my satisfaction.

Printed Name_____

_____ _____

Patient Signature Date

Accident or Worker Compensation Acknowledgement

(Required for all patients)

Is this physical therapy case related to a **Motor Vehicle Accident (MVA)**?
Yes No

Is this physical therapy case related to a **Worker Compensation Accident**?
Yes No

If you answered yes to either question, please continue to complete the information below:

In which state was the accident?

What is the name of the MVA or Worker Compensation insurance responsible?
(Include name of policy holder, insurance address, phone number, policy number)

What is the claim number?

Please provide the case worker's name and contact information:

Patient's Printed Name_____

Signature_____**Date**_____