Welcome to Paramount Physical Therapy

Welcome to our clinic! We are pleased you have chosen us for your rehabilitation needs. Our goal is to provide you with the highest quality care. Before you begin your therapy program, an evaluation will be performed to assess your individual needs. The evaluation will take 30-45 minutes depending on your diagnosis and individual needs. It is important to come to your evaluation 15 minutes early to complete the necessary paperwork if this has not been completed beforehand. You can also save time by filling out the paperwork ahead of time.

When you come for your evaluation you should bring the following information:

1. Therapy prescription from your physician
2. Insurance Card
3. Co-pay
4. List of medication you are currently taking
5. Drivers License and Insurance Card

Appointments:
Patients are seen by appointment only. After your evaluation, schedule follow-up visits with your therapist. Your therapist will discuss appropriate frequency and duration of treatment. It is critical that you are on time for your appointments. Showing up late may shorten your therapy session so that other patients' scheduled appointments are not disrupted.

Appropriate Attire:
Please wear clothes that are suitable and comfortable for performing exercise. If you have a knee problem please wear shorts to better access your knee directly.

Attendance Policy:
It is very important that you attend all of your scheduled visits. If you can not attend, we require that you call 24 hours in advance so that we can fill your scheduled visit with another patient. Inconsistent attendance may result in dismissal from therapy intervention and the inability to return without a doctor order.

Regular Attendance and Active Participation:
It is necessary to get the maximum benefit from our services; therefore requires open communication with your therapist and consistent participation.

Complaints and or Recommendations:
We encourage our patients to openly communicate with our staff and provide question, concerns, and recommendations so that we may enhance the quality of care provided
If you have any questions regarding our services, please call 517 420 8266.
We look forward to working with you!

Past Medical History Questionnaire

Patient Name		**Date of Birth**	
Reason for Therapy		Date of Injury or Onset	
Have you ever received therapy for the condition mentioned above? ☐No ☐Yes		If so, when?	
Treatment Received:		Previous Treatment: ☐Successful ☐Unsuccessful	

Could you be or are you pregnant: ☐No ☐Yes

Do you now or have you ever had any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Arthritis	☐	☐	**Diabetes**	☐	☐	**Thyroid Problems**	☐	☐
Osteoporosis	☐	☐	**Anemia**	☐	☐	**Headaches**	☐	☐
High Blood Pressure	☐	☐	**Hypersensitivity to Heat/Cold**	☐	☐	**Head Injury / Concussion**	☐	☐
Heart Disease	☐	☐	**Swelling in Ankles**	☐	☐	**Hernia**	☐	☐
Heart Attack	☐	☐	**Deep Vein Thrombosis (DVT)**	☐	☐	**Kidney / Bladder Problems**	☐	☐
Pacemaker	☐	☐	**Seizures / Epilepsy**	☐	☐	**Previous Fractures**	☐	☐
Vascular Disease	☐	☐	**Metal in Body or Surgical Implants**	☐	☐	**Previous Surgeries**	☐	☐
Stroke	☐	☐	**Cancer/Tumor**	☐	☐	**Hearing Loss**	☐	☐
Asthma	☐	☐	**Recent Weight Loss or Gain**	☐	☐	**Depression**	☐	☐
Shortness of Breath	☐	☐	**Current Infection(s)**	☐	☐	**Anxiety**	☐	☐
Chronic Cough	☐	☐	**Tuberculosis**	☐	☐	**Substance Abuse**	☐	☐
Fainting Spells	☐	☐	**Hepatitis**	☐	☐	**Other**	☐	☐

If you answered "yes" on any of the above, please explain and give approximate date(s):

Do you have any allergies? ☐No ☐Yes, list allergies:

Are you presently taking any medications? ☐No ☐Yes, list medications and specify condition:

As part of our Certified Rehabilitation Program, our facility offers social and/or vocational adjustment services. Do you believe you may be in need of these services? ☐No ☐Yes

The information is correct to the best of my knowledge.

X Patient/Parent/Guardian Signature	Date

FINANCIAL AGREEMENT

Our practice is committed to providing the best treatment for our patients and we charge what is reasonable and acceptable within the guidelines as published by the Center for Medicare/Medicaid Services.

Many carriers implement an arbitrary schedule of allowances. Notwithstanding any contractual provision to the contrary between Paramount Physical Therapy and your health insurance carrier, Paramount Physical Therapy will accept your carrier's fee schedule allowance as full payment for any service rendered provided that you meet any co-insurance, co-payment, and/or deductible obligation assigned by your carrier within 60 days of the date of the carrier's determination as expressed on your explanation of benefits. This statement does not mean that we accept the carrier's payment in full.

Your carrier generally only pays a portion or percentage of the allowed fee for a particular service in accordance with the terms of your benefit plan. Deductible, co-insurance and/or co-payment amounts are your responsibility. Where payment of amounts assigned to you by your insurance carrier is not made within 60 days of your carrier's determination, the amounts in excess of your insurance carrier's fee schedule allowance will be due and payable. Where a service is not covered under your benefit plan, you will be responsible for the fee charged for such services. Additionally, we reserve the right to appeal your carrier's determination regarding the amount allowed for any service we provide where the amount allowed is less than the amount charged. The amount you may be responsible for could therefore change depending on the outcome of such an appeal.

Co-pays, Deductibles, Co-insurance and Outstanding Balances: All co-payments, co-insurance and/or co-payments and deductible amounts are required to be paid under the terms of your contract with your insurance carrier and they are due and payable at the time of check-in, prior to your appointment with the Practitioner.

We kindly ask that all patients provide us with a valid credit card to be used only if any charges are not covered by your insurance plan. Your card will only be charged after all payments have been received from your insurance company, and it is determined that you are responsible for the balance. We will charge your card for the balance owed by you (as determined by your insurance carrier) after 60 days following the initial statement. We will charge your card based on the statement called an Explanation of Benefits (EOB) that we receive from your insurance carrier. If your card is charged, we kindly ask you to contact your insurance plan for an explanation of any concerns as our charges are based solely on the information they have provided us. Credit card information is maintained confidentially by our merchant account.

_____/_____

Patient Name / Name on Credit Card Date

_____ _____

Credit Card Number Expiration

_____ _____ _____

Address associated to Credit Card Provided ZIP Code CVV Code (back of card)

X_____ _____

Signature of Authorized Signer Date

A $25.00 service charge will be applied to your account for all returned checks.

Non-Covered Services: Your care may involve services that are not covered under your health benefit plan. You have the right to deny receipt of these services. If you elect to receive a non-covered service that is recommended or necessary to your care, you will be fully responsible for payment of these services. Where circumstances permit, we will attempt to verify the limitations of your health insurance benefit plan recognizing that you have the ultimate responsibility for knowing and understanding the coverage limitations of your insurance benefit contract. As the information we receive is not a guarantee of coverage or benefits, we cannot be responsible for the validity of the information supplied to us by your carrier. You are responsible to verify your coverage limitations based on your benefit contract.

Adult Patient: Adult patients are responsible for full payment at time of service unless we are accepting assignment for insurance. For patients without insurance coverage, you agree to be responsible in full for all services provided in accordance with our negotiated fee schedule.

Minor Patient: The adult accompanying a minor and the parents (or guardian of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless patient responsibility has been paid in advance of treatment, via credit card, check, or cash.

Self-Pay : Self-pay individuals will be expected to pay in full at the time of service.

Cancellations and Missed Appointments: Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $60.00. Please help us serve you better by keeping scheduled appointments. Further, understand that noncompliance with your ordered treatment plan may negate our ability to represent your services.

Danielle Wehrman DPT, owner and operator of Paramount Physical Therapy, reserves the right to approve or deny payment plan arrangements on a case-by-case basis.