

**NEW PATIENT PAPERWORK**

**Physical Therapy Institute of the Northwest**

Jessica Gardner, PT, DPT • Kaven Musgrove, PTA  
8921 W. Hackamore Dr. Boise ID 83709  
Phone # 208-375-7035 • Fax # 208-377-7707

**PHYSICAL THERAPY INSTITUTE OF IDAHO MEDICAL HISTORY FORM**

PATIENT E-MAIL: \_\_\_\_\_

DATE OF INJURY OR ONSET: \_\_\_\_\_

WHAT IS YOUR REASON FOR ATTENDING THERAPY?  
\_\_\_\_\_

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (Check all that apply)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> ANEMIA   | <input type="checkbox"/> CARDIOVASCULAR PROBLEMS  | <input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> ARTHRITIS  | <input type="checkbox"/> FRACTURES <input type="checkbox"/> HOLTER MONITOR - currently wearing?             | <input type="checkbox"/> KIDNEY PROBLEMS   |
| <input type="checkbox"/> ASTHMA <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled   | <input type="checkbox"/> HEADACHES  | <input type="checkbox"/> BLOOD THINNERS (Anticoagulants)   |
| <input type="checkbox"/> DIABETES <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled | <input type="checkbox"/> SEIZURES <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled | <input type="checkbox"/> LOW BLOOD PRESSURE  |
| <input type="checkbox"/> DEPRESSION   | <input type="checkbox"/> PACEMAKER  | <input type="checkbox"/> MRSA (Methicillin Resistant Staphylococcus Aureus)  |
| <input type="checkbox"/> CANCER   | <input type="checkbox"/> HEPATITIS/HIV  | <input type="checkbox"/> CURRENTLY PREGNANT  |
| <input type="checkbox"/> DIZZINESS/FAINTING   | <input type="checkbox"/> THYROID PROBLEMS   | <input type="checkbox"/> OSTEOPOROSIS  |
| <input type="checkbox"/> COPD <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled     |   |  |

If checked any above, explain:

ANY OTHER MEDICAL PROBLEMS: \_\_\_\_\_

**Emergency / Other Contacts**

Name	Primary Phone	Secondary Phone	Email

## Patient Intake and Consent Form

<p><b>Consent to Treatment</b>          I consent to rehabilitation and related services at: <b>Physical Therapy Institute of the Northwest</b>          In doing so, I understand, acknowledge, and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature.</p>	<p><b>Initials</b>  _____</p>
<p><b>Treatment of Minors</b>          I, as a parent/guardian of a minor receiving treatment hereunder, to hereby agree and understand that I have been advised to remain on the premises during any such treatment and waive any claim that I may have resulting from a failure to do so.</p>	<p><b>Initials</b>  _____</p>
<p><b>Liability</b>          I know and agree that: <b>Physical Therapy Institute of the Northwest</b> is not responsible for loss or damage to personal valuables.</p>	<p><b>Initials</b>  _____</p>
<p><b>Waiver and Release</b>          I hear by release, discharge and acquit: <b>Physical Therapy Institute of the Northwest</b>, its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and/or medical services including but not limited to ambulance service, emergency medical technician, physician, or urgent care services.</p>	<p><b>Initials</b>  _____</p>
<p><b>Authorization of Payment</b>          I hereby assign all benefits directly to <b>Physical Therapy Institute of the Northwest</b>.          I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment to other third parties as necessary to process medical claims and as otherwise permitted or required in the notice of privacy.</p>	<p><b>Initials</b>  _____</p>
<p><b>Financial Policy</b>          I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.          To assist in establishing your account, please:</p> <ul style="list-style-type: none"> <li>- Supply all necessary information for accurate billing of your claim, including your insurance card driver's license employer information and demographic information.</li> <li>- Satisfy all insurance copayments, coinsurance, deductibles, and noncovered services on the day services are rendered.</li> <li>- Provide your insurance company and us any additional information requested to complete the processing of your claims filed on your behalf.</li> <li>-</li> </ul>	<p><b>Initials</b>  _____</p>
<p><b>Notice of Privacy/Patient Bill of Rights</b>          I acknowledge receipt of notice of privacy practices.          I acknowledge receipt of the statement of patient rights.</p>	<p><b>Initials</b>  _____</p>
<p>I certify that all the information provided herein is true and correct.</p> <p><b>Patient Signature</b> _____ <b>Witness Signature</b> _____</p>	<p><b>Date</b>  _____</p>

## Payment Process / Policy

We agree to submit your medical bill for payment to the insurance carrier who is primarily responsible for payment and agree to receive payment directly from the responsible insurance carrier. Responsible insurance carriers may be your personal medical plan or health insurance, your auto or homeowner's liability insurance, your employer's workers' compensation insurance plan, or a third-party liability insurance carrier. If your medical plan or health insurance includes a deductible and co-insurance provision, we will bill the patient or guarantor as directed by your plan or policy. Responsibility for payment begins the date services are provided. A billing statement will be sent to you from the billing entity name and address above to advise you of any amounts due.

Provisions in our participating provider contracts with health insurance company's request, permit, and, in many instances, direct us to send your bill to the third-party liability insurance carrier for full payment before we send it to your medical plan or health insurance for payment. For example, if your treatment was for injuries caused by someone else, we will submit your bill to the other person's insurance company (third party liability insurance carrier) for payment in full, before we send your bill to your health insurance to pay. If the total unadjusted amount of your bill is \$10,000, for example, we will ask the other person's insurance company to pay the entire \$10,000. No health insurance contractual adjustments will be made to your bill prior to submitting it to the other person's insurance company – we will submit the full, unadjusted amount for payment.

Co-pays, deductibles, limits, and contractual adjustments only apply to bills sent directly to your medical plan or health insurance for payment. They do not apply to bills sent to third party liability carriers for payment. If you do not have health insurance, we ask that you pay \$275.00 as a deposit for your first visit.

In cases where a third-party liability insurance carrier is involved, such as in an auto accident, a lien may be placed, in accordance with Idaho Code § 45-701, et seq., with the third-party liability insurance carrier. If you are injured in a work-related accident, we will submit your bill directly to the workers' compensation insurance carrier. If your worker's compensation claim has been properly filed with and accepted by the Idaho Industrial Commission, there will be no charges incurred by you. If your claim is denied or is not paid in accordance with IDAPA 17.02.09, any remaining balance will be your responsibility.

If you have a balance due after all possible insurance carriers have paid, or if you do not have insurance, the following options are offered:

- Payments by cash, check, or credit card, or CareCredit
- Short term internal payment plans not to exceed three (3) months
- We reserve the right to charge interest on balances over 120 days old from date of service. The fee is assessed annually at 12% or a monthly interest rate of 1%.
- **Cancellations under 24 hours or no-shows are subject to \$100.00 cancellation/no show fee per visit.**

**Cancellations:** The patient will call and give a 24-hour notice to cancel their appointment in order to give the clinic time to offer their appointment to another patient.

**No Shows:** The patient will be marked as a no show if they are 10 minutes or later for their appointment. Patient has option to call and reschedule for a later date. After 3 no shows patient will be removed from the clinic's schedule.

I have read the information about how the payment process and attendance policy works. I understand and agree that I am financially responsible for the payment of medical charges incurred on my behalf as outlined above.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print: \_\_\_\_\_



## Notice of Good Faith Estimate

You have the right to receive a “Good Faith Estimate” explaining how much your medical care will cost. Under the law, health care providers need to give patients who do not have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request.
- If you schedule your appointment at least three business days in advance, we will give you a Good Faith Estimate in writing within one business day after scheduling at your request. If you schedule your service at least ten days in advance, we will give you a Good Faith Estimate in writing within three business days after the appointment is scheduled at your request. You can also ask us for a Good Faith Estimate before you schedule your appointment, which we will provide within three business days.
- If you receive a bill that is at least \$400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate and bill.

For questions or more information about your right to a Good Faith Estimate, visit [www.cms.gov/nosurprises/consumers](http://www.cms.gov/nosurprises/consumers), email [FederalPPDRQuestions@cms.hhs.gov](mailto:FederalPPDRQuestions@cms.hhs.gov), or call 800- 985-3059.

## Aviso de estimación de buena fe

Usted tiene derecho a recibir un "Estimado de Buena Fe" que explique cuánto le corresponde a su atención médica costará.

Según la ley, los proveedores de atención médica deben dar a los pacientes que no tienen seguro o que no están utilizando el seguro una estimación de la factura de artículos y servicios médicos.

- Usted tiene derecho a recibir una Estimación de Buena Fe por el costo total esperado de cualquier artículos o servicios de atención médica a pedido o al programar su cita.
- Si programa su cita con al menos tres días hábiles de anticipación, le daremos usted una estimación de buena fe por escrito dentro de un día hábil después de la programación a su solicitud. Si usted programe su servicio con al menos diez días de anticipación, le daremos una estimación de buena fe por escrito dentro de los tres días hábiles posteriores a la fecha programada para su solicitud. También puede solicitarnos un presupuesto de buena fe antes de programar su cita, que le proporcionaremos dentro de los tres días hábiles.
- Si recibe una factura que es de al menos \$400 más que su estimación de buena fe, puede disputar la factura.
- Asegúrese de guardar una copia o imagen de su estimación y factura de buena fe.

Para preguntas o más información sobre su derecho a una estimación de buena fe, visite [www.cms.gov/nosurprises/consumers](http://www.cms.gov/nosurprises/consumers), envíe un correo electrónico a [FederalPPDRQuestions@cms.hhs.gov](mailto:FederalPPDRQuestions@cms.hhs.gov) o llame al 800-985-3059.

(continued on next page)

## **Your Rights and Protections Against Surprise Medical Bills and Balance Billing**

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

### **What is “balance billing” (sometimes called “surprise billing”)?**

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

Out-of-network describes providers and facilities that haven't signed a contract with your health plan.

Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “balance billing.”

Surprise billing is an unexpected balance bill. This can happen when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

### **You are protected from balance billing for:**

#### **Emergency Services**

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount.

You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

#### **Certain services at an in-network hospital or ambulatory surgical center:**

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, surgeons and assistant surgeons, hospitalists, or intensivist services. These providers can't balance bill you and cannot ask you to give up your protections not to be balance billed. If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections. **You're never required to give up your protections from balance billing and you also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.**

#### **When balance billing isn't allowed, you also have the following protections:**

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles) that you would pay if the provider or facility was in-network. Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
- Cover emergency services without requiring you to get approval for services in advance.
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility on what it would pay an in-network provider or facility.
- Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

(For **Good Faith Estimate** and **Rights and Protection**, Please sign below)

Signature \_\_\_\_\_ Date \_\_\_\_\_