NEW PATIENT PAPERWORK

Physical Therapy Institute of the Northwest
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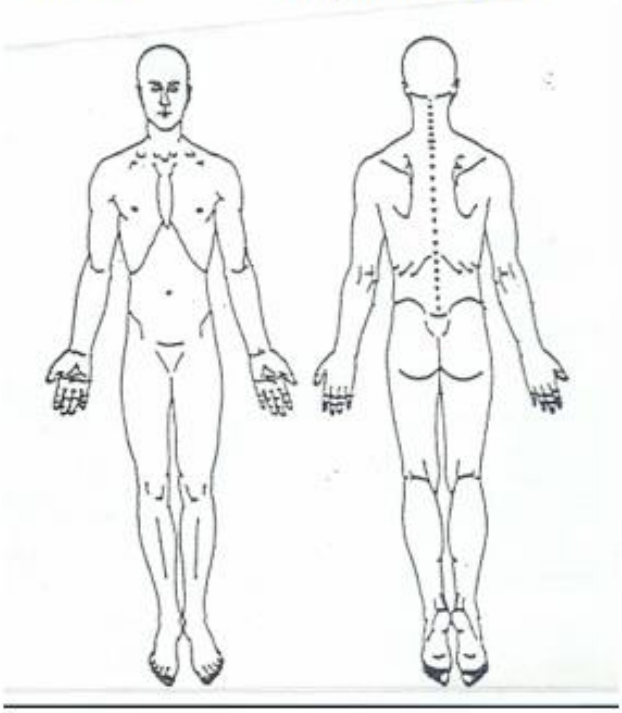
Pain Diagram and Pain Rating

Name: _____ **Date:** _/_____/_____

INSTRUCTIONS: Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. Use the key to indicate the type of symptoms.

KEY:

Pins and Needles	**= 000000**	**Stabbing**	**= / / / / / /**
Burning	**= xxxxxx**	**Deep Ache**	**= zzzzzz**



Please rate your current level of pain on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Please rate your worst level of pain in the last 24 hours on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Please rate your best level of pain in the last 24 hours on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

PHYSICAL THERAPY INSTITUTE OF IDAHO MEDICAL HISTORY FORM

PATIENT NAME: _____ TODAY'S DATE: _____
REFERRING PHYSICIAN'S NAME: _____ DATE OF INJURY OR ONSET: _____
PRIMARY CARE PHYSICIAN'S NAME: _____ ARE YOU PRESENTLY WORKING? YES NO
CAUSE OF INJURY OR ONSET: _____ DATE OF NEXT MD APPT: _____
DO YOU CURRENTLY HAVE ANY "FLU TYPE" SYMPTOMS (I.E. FEVER, COUGHING)? YES NO
IF YES, WHAT SYMPTOMS:
_____
DO YOU HAVE ANY OPEN CUTS, LESIONS OR WOUNDS? YES NO IF YES, WHERE: _____
HAVE YOU FALLEN IN THE PAST YEAR? YES NO IF YES, HOW MANY TIMES: _____
IF YES TO FALLING, DID YOU SUSTAIN AN INJURY AS RESULT OF THE FALL? YES NO

WHAT IS YOUR REASON FOR ATTENDING THERAPY?
_____
BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?
1. _____
2. _____
3. _____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?
1. _____
2. _____
3. _____

DESCRIBE YOUR GENERAL HEALTH: EXCELLENT GOOD FAIR POOR
DO YOU USE TOBACCO? YES NO IF YES, HOW MUCH? _____
WEAR GLASSES / CONTACTS? YES NO

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO IF YES, WHEN _____
AND WHY _____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? YES NO
WHAT WAS DONE? / WHAT WERE THE RESULTS?
_____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY THIS CALENDAR YEAR? YES NO
WAS IT RECEIVED AT: HOSPITAL OUTPATIENT CENTER HOME HEALTH FOR HOW LONG? _____
CURRENT MEDICATIONS: _____
ALLERGIES: Medication _____ Reaction _____ Other _____ Reaction_____
ARE YOU ALLERGIC TO LATEX? YES NO If yes, what is the Reaction _____
Are you Allergic to Dexamethasone? YES NO If yes what is the Reaction _____
DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (Check all that apply)

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

If checked any above, explain:
_____
□ ANY OTHER MEDICAL PROBLEMS: _____

SIGNATURE OF PATIENT: _____ REVIEWED BY Therapist: _____ Date_____

Patient Intake and Consent Form

Consent to Treatment I consent to rehabilitation and related services at: **Physical Therapy Institute of the Northwest** 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.	Initials _____
Treatment of Minors 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.	Initials _____
Liability I know and agree that: **Physical Therapy Institute of the Northwest** is not responsible for loss or damage to personal valuables.	Initials _____
Waiver and Release I hear by release, discharge and acquit: **Physical Therapy Institute of the Northwest**, 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.	Initials _____
Authorization of Payment I hereby assign all benefits directly to **Physical Therapy Institute of the Northwest.** 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.	Initials _____
Financial Policy 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: - Supply all necessary information for accurate billing of your claim, including your insurance card driver's license employer information and demographic information. - Satisfy all insurance copayments, coinsurance, deductibles, and noncovered services on the day services are rendered. - Provide your insurance company and us any additional information requested to complete the processing of your claims filed on your behalf. -	Initials _____
Notice of Privacy/Patient Bill of Rights I acknowledge receipt of notice of privacy practices. I acknowledge receipt of the statement of patient rights.	Initials _____
I certify that all the information provided herein is true and correct. **Patient Signature** _____ **Witness Signature** _____	Date _____

Emergency / Other Contacts

Name	Primary Phone	Secondary Phone	Email

Disclosure of Medical Records

I authorize the following individuals to have access to my medical and billing records:

Name	Relationship
Name	Relationship

Signature of Patient	Date

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:

- Online payments at: www.idneuro.com
- 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 are subject to $100.00 cancellation/no show fee per visit.**

Patients with financial constraints should speak to a financial counselor for assistance. We will not deny critical care to anyone due to inability to pay or lack of insurance. If surgery is indicated and a financial hardship is determined, we will assist in obtaining available coverage, such as county assistance or Medicaid. If you have the ability to pay your bill but refuse to pay under the terms defined above, your account may be turned over to a collection agency.

I have read the information about how the payment process 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: _____ Date of Birth: _____

Cancellation / Reschedule / No Show Policy

Purpose: To minimize disruption in the scheduling process, disruptions in the delivery of care, and reduce cost to the clinic in terms of lost revenue and wasted staff efforts.

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. Same day cancellations will only be allowed to reschedule the missed appointment for the following week.

Patients arriving more than 10 minutes late have 2 options:

1.) The patient can reschedule for another day depending on availability. The patient will be marked as a No Show for the day.
2.) The patient can be worked into today's schedule. The patient may have to wait as priority will be given to the patients who are on time for their appointments.

No Shows: The patient will be allowed 5 No Shows in a 12-month period. If the patient wishes to schedule after their 5th No Show, they will have to speak with the Office Manager. The Office Manager and the treating Therapist will discuss whether the patient will be allowed to schedule again. The patient will be notified of the clinic's decision. If the patient misses the appointment scheduled after their 5th No Show the patient will be discharged to a home exercise program. A letter will be written to the patient's referring Doctor explaining why the clinic discontinued the patient's plan of care.

By signing, the patient has agreed to and understands this clinic's attendance policy.

Signature: _____ Date: _____

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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, email 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, envíe un correo electrónico a FederalPPDRQuestions@cms.hhs.gov o llame al 800-985-3059.

Signature_____Date_____

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 balanced 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.

Note: South Carolina does not have a state law in place to prevent surprise medical billing but will be covered under the federal law that takes effect on Jan. 1, 2022.

Signature_____Date_____