How did you hear about us? ☐ Physician ☐ Friend ☐ Radio ☐ TV ☐ Newspaper ☐ Other:_______________

PERSONAL INFORMATION: (PLEASE PRINT LEGIBLY)

Today's Date: ______________________ Email____

Last Name: ____ First Name: __________________________ MI:_________

Patient's DOB: _______________ Age: _________ Sex: M F

Patient's Social Security Number:____ Student: ☐ Yes ☐ No

Mailing Address:____

City: ____ State:______________________ ZIP: ______________

Home Phone:________________________ Cell Phone: ________________________ Work Phone: ______________________

Employer: ___________________________ Address: _______________________________ State: _____ ZIP: _______________

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

INSURANCE INFORMATION:

Who is responsible for this insurance account? ___________________ Relationship to Patient:_______________________________

Primary Insurance:____

Address: ______________________________________ City: ___________________ State: _______ ZIP: ______________

ID/Case #: _____________________________________ Group # ____

Insured Name:__________________________________ DOB: __________________ SSN#:__________________________

Secondary Insurance: ____

Address: ______________________________________ City: ___________________ State: _______ ZIP: ______________

ID/Case #: _____________________________________ Group # ____

Spouse/Parent/Guardian Name:____ Relationship: ______________________

DOB:______________________ Social Security Number: ______________________ Phone: __________________________

Mailing Address:____

City: ____ State: _____________________ ZIP: ______________

Employer: ____ Occupation:____

EMERGENCY CONTACT NAME:____ Phone: __________________________

Relationship to Patient : ____________________________________ Alt Phone: _______________________

Are you or could you be pregnant? ☐ Yes ☐ No

Tobacco Use? ☐ Yes ☐ No If "YES", how often? _______________

Are you allergic to:

Adhesive Tape: ☐ Yes ☐ No

Any Medications: ☐ Yes ☐ No

If "YES", please list: ____

____

Please list surgical procedures: ____

____

YOUR Medical History   Please indicate if **YOU** have a history of the following:

☐ Alcohol Abuse	☐ Broken/Cracked Bones	☐ Lung/Respiratory Disease
☐ Anemia	☐ Concussion/Head Injury	☐ Major Traumatic Injury
☐ Anxiety Disorder	☐ Depression	☐ Mental Illness
☐ Arthritis	☐ Diabetes	☐ Migraines
☐ Asthma	☐ Heart Disease	☐ Osteoporosis
☐ Autoimmune Problems	☐ HIV	☐ Steroid Use
☐ Bleeding Disease	☐ High Blood Pressure	☐ Thyroid Problems
☐ Blood Clots/DVT	☐ High Cholesterol	
☐ Cancer	☐ Loose Joints	☐ None of the above

ASSIGNMENT AND RELEASE

I, the under signed, certify that my dependent or I have insurance coverage with

____, and assign directly to Bluffs Physical Therapy, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize that Bluffs Physical Therapy, LLC can release all information necessary to secure the payment of benefits. I further authorize Bluffs Physical Therapy, LLC to contact the Insurance Commissioner on my behalf in the event of insurance problems. I authorize the use of this signature on all insurance submissions.

______________________________   ________________________   ____________

Responsible Party Signature   Relationship   Date

MEDICARE ONE TIME AUTHORIZATION:

I, ____________________________ , request that payment of authorized Medicare benefits be made to Bluffs Physical Therapy, LLC on my behalf for any services, physical therapy or soft goods, furnished to me by Bluffs Physical Therapy, LLC. I authorize Bluffs Physical Therapy, LLC to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or benefits payable for related services. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, Bluffs Physical Therapy, LLC agrees to accept the charge determination of the Medicare carrier as the full coverage. The patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the character determination of the Medicare carrier.

____   ________________________________

Beneficiary Signature (Medicare only)   Date

- I have read the above and I agree to the terms.
- I hereby acknowledge receipt of a copy of this form.
- I hereby authorize Bluffs Physical Therapy, LLC to perform such treatments and procedures the physician has ordered for treatment.
- I understand that Bluffs Physical Therapy, LLC will hold all my information regarding my condition confidential.
- I hereby give my permission to release necessary information to my insurance company, attorney, medical doctor, Medicare, Medicaid, and/or Worker's Compensation.

____   ________________________________

PRINTED Name of Patient   **SIGNATURE of RESPONSIBLE**

Please **SIGN** the following acknowledgement.

I was offered a copy of the Notice of Privacy Practices from Bluffs Physical Therapy, LLC or a designated affiliate. HIPAA Notice of Privacy Practices available upon request.

___________________________________ ____________

Patient Signature (or responsible party) Date

This acknowledgement will be filed with your records.

STANDING AUTHORIZATION FOR RELEASE OF INFORMATION TO SPECIFIC PERSON(S)

NAME:_____________________________ DOB:_______________

May we reach you or the below mentioned persons by phone?______________

Let it be known to all persons associated with Bluffs Physical Therapy, LLC that the following individuals may be given information that I am on the premises. Let it also be known that the following person(s) may receive information regarding my appointments, medical conditions, insurance and billing information.

NAME:__________________________ RELATIONSHIP:_______________________
NAME:__________________________ RELATIONSHIP:_______________________
NAME:__________________________ RELATIONSHIP:_______________________

☐ None

ACKNOWLEDGEMENT

I understand that any information disclosed by this authorization may be subject to received disclosure by the recipient and will no longer be protected by HIPAA. The Facility and all personnel covered under this entity are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

EXPIRATION

I understand that I may revoke this authorization by submitting a written notice to Bluffs Physical Therapy, LLC. This notice will remain in effect until such time it is revoked.

Patient Signature:_____________________________________ Date:_________________

Representative Signature:________________________________ Date:_________________

Relationship to patient if not named above:____

Welcome! Thank you for selecting our office. It is our goal to provide your physical therapy needs as thoroughly and efficiently as possible. To do that, we need to work with you as a team.

As part of the team you need to know and understand a few things. Before we begin we will discuss and explain our treatment plan. Depending on your progress the plan may need to be changed. An estimate of the total fee for your treatment is virtually impossible because we cannot tell how long it will take you to progress. We will be able to tell you how much each treatment costs. If you are uncertain of any change or cost feel free to ask. We are more than happy to answer your question. Your physician will then be contacted for permission to treat a new diagnosis.

Our policy regarding payment for our professional services is as follows:

A: Cash, check or major credit card will be accepted at the time of treatment. Any account not paid in full 90 days after treatment will bear interest at the rate of 1.5% per month or 18% per annum.

B: Treatment involving any laboratory work, braces, orthotics or prosthetic devices may require a percentage of the total fee be paid before treatment begins or the device is ordered. This is necessary to cover the laboratory fees or the cost of the device we must pay in advance.

C: In the event we have to use an attorney to collect any unpaid balance due for services to you or your family by signing the information form upon your first visit you agree to pay all costs of collection, including all attorney fees whether suit is filed or not.

INSURANCE: As a courtesy to our patients we will file your primary insurance and secondary insurance. Please check your insurance policy prior to service to be sure physical therapy / occupational therapy is covered.

MEDICARE:
Bluffs Physical Therapy, LLC accepts Medicare assignment, Medicare payment will be made directly to the provider. The provider agrees to accept the Medicare approved amount as full payment for covered services. The beneficiary may be billed for the 20% coinsurance, any unmet deductible and for services not covered by Medicare. A Doctor's referral is required every 30 days. Medicare Part B helps pay for medically necessary outpatient physical and occupational therapy services. There are limits on these services. The therapy cap limits for 2018 are:

- $2,010.00 for physical therapy
- $2,010.00 for occupational therapy

Softgoods or Durable Medical Equipment are not a covered benefit (ie, knee brace, orthotics, back brace). Medicare requires that patients see their physician every 30 days.

MEDICAID:
There is a visit limit for all Medicaid patients. Please check with our office staff for the exact limit. Softgoods or Durable Medical Equipment are not a covered benefit (ie, knee brace, orthotics, back brace).

WORKERS' COMPENSATION:
We will process Workers' Compensation; however, you are required to let us know that you have a workers' compensation claim, and you must provide us with your case number, date of injury,social security number and employer's address. If we do not receive a case number from you, or if your claim is denied you will be responsible for all charges incurred. If your case is under objection you will receive a bill from us until your case is resolved. You must be in constant contact with your caseworker. If there is new information please let us know.

CAR INSURANCE:
Stay in contact with your claims adjuster. If there is new information please let us know.

AUTHORIZATION AND/OR REFERRAL REQUIRED
YES – REFERRAL IS REQUIRED FOR ALL INSURANCES.
IF IT IS WORKERS' COMPENSATION AUTHORIZATION IS REQUIRED.

We at Bluffs Physical Therapy, LLC strive to help you with all your insurance questions or concerns. As a reminder, any benefits quoted are not a guarantee of benefits. By signing this form, you are responsible for all accrued charges during your treatment at Bluffs Physical Therapy, LLC.

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PATIENT SIGNATURE (or responsible party) DATE