BLUFFS
PHYSICAL THERAPY

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 Other

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

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

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: _____

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 : _____

CONSENT TO TREAT/HIPPA AUTHORIZATION CONSENT

- I hereby authorize Bluffs Physical Therapy, LLC to perform such treatments and procedures the physician has ordered or that the doctor of physical therapy has determined necessary 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.
- I was offered or may request a copy of the Notice of Privacy Practices from Bluffs Physical Therapy, LLC or a designated affiliate.

_____ _____

SIGNATURE of RESPONSIBLE PRINTED Name of Patient

ASSIGNMENT AND RELEASE FOR BILLING

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. We will be able to tell you how much each treatment costs. If you are uncertain of any charge 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 to 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 must 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 the 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 approved Medicare 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 and occupational therapy services.

Softgoods or Durable Medical Equipment are not a covered benefit (i.e., 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. Soft goods or Durable Medical Equipment are not a covered benefit (i.e., 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. I hereby authorize that Bluffs Physical Therapy, LLC can release all the 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.

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.

_____ _____

PATIENT SIGNATURE (or responsible party) DATE

BLUFFS
PHYSICAL THERAPY

Attendance Policy

Our patients come FIRST at Bluffs Physical Therapy, and in order to maintain the level of care we provide, we expect you to keep the appointment time we have saved especially for you. **A 'Cancellation Fee' of $50.00 will be assessed for all appointments that are missed or canceled within 24 hours of appointment time.** We respect your time, and we look forward to maintaining the dedication we are known for to getting you to the highest levels achievable in your rehabilitation.

Please sign and date below indicating you understand this policy and will do your absolute best to abide by it, and the Bluffs PT team will return the favor by giving you the fantastic care you deserve.

_____ _____

Patient Signature Printed Name

_____ _____

Parent Signature (only if patient is a minor) Printed Name

_____

Date

BLUFFS
PHYSICAL THERAPY

Your Physical Therapy Experience

At Bluffs PT, we understand that both our clinical work and your efforts outside our visits are crucial to your progress.

We recognize the challenges of dedicating time and energy to your well-being and are committed to supporting you in **regaining your quality of life.**

How We're Different

The Bluffs PT Experience program enables daily communication with you **via text messaging.**

We'll inquire about your symptoms, function, and home plan..

Your daily response to the text messages allows us to check in on your progress remotely and adjust your care plan in real-time, ensuring continuous support even on days you're not in the clinic.

Your Care Beyond the Clinic

This service offers **access to your provider** even when you're not in the clinic - for questions, advice, and recommendations, in addition to reminders for your home plan.

Text engagement has been proven to **enhance outcomes** and **reduce time in physical therapy**, therefore **saving you time and money** while accelerating your return to daily life.

Moreover, most insurance companies cover this service!

Please provide your cell phone number to sign up for the Bluffs PT Experience.

_____
Cell

_____
Signature

_____
Date