FIRST STEP
PHYSICAL THERAPY

2023 PATIENT INFORMATION

Welcome to the **First Step Physical Therapy** family!
Thank you for selecting our practice for your physical therapy needs

PATIENT NAME: _____DATE: _____

IF CHILD, PARENT/GUARDIAN'S NAME(S) _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL: _____

EMAIL ADDRESS: _____

DATE OF BIRTH: _____ SSN: _____

Do you have a Power of Attorney? Please Circle One: YES NO

IF YES:

POWER OF ATTORNEY NAME: _____PHONE: _____

REFERRING PHYSICIAN: _____ PHONE: _____

CITY: _____ STATE: _____ ZIP: _____

Emergency Contact:

NAME: _____ PHONE: _____ RELATIONSHIP: _____

FIRST STEP PHYSICAL THERAPY

2023 CANCELLATION POLICY

First Step Physical Therapy is pleased to be able to assist you with your individual recovery program. We will do everything within our power to schedule you for the treatment days and times that you desire.
In return, due to our 1:1 therapist to patient ratios, we request **at least 24-hour notice** when you must cancel your scheduled appointments:

- There is a **$50 per hour** cancellation fee for appointments canceled with less than 24-hour notice
    - Doctor note, school note, and/or extenuating circumstances will be taken into consideration as an exception to the 24 hour cancellation notice
- Persons with more than 3 late cancellations will not be able to schedule more than 1 week in advance
- Persons with more than 5 late cancellations will only be allowed to schedule appointments the day prior

Credit Card Authorization Form

Please complete all fields. You hereby authorize First Step Physical Therapy to charge the below card $50 per hour for appointments canceled with less than a 24-hour notice. This authorization form will remain in effect until canceled.

Credit Card Information
Card Type: ☐ **MasterCard** ☐ **VISA** ☐ **Discover** ☐ **AMEX**
Cardholder Name (as shown on card): _____
Card Number: _____
CVV Code: _____
Expiration Date (mm/yy): _____
Cardholder billing ZIP Code: _____

I have read thoroughly and agree to abide by the above Cancellation Policy

Patient Name (printed)**:**_____ Signature:_____

Date_____

FIRST STEP PHYSICAL THERAPY

2023 PAYMENT AND FEE POLICY

Physical Therapy Evaluation $210

Physical Therapy Treatment Hour $185

1. Methods of payment are cash, check, Visa, Master Card, Discover, American Express and HSA cards.
2. A $50 fee is charged for all checks that are returned due to insufficient funds
3. A 4% processing fee will be added to credit and debit cards charged in the office
4. Patients are required to pay their insurance co-pay on the date of service
5. Patient accounts with unpaid services reaching 90 days past date of services will be handled as follows:
    - Scheduling of services will be suspended
    - Monthly payments of at least 10% of remaining balance will be required until the account is paid in full
    - Failure to comply with at least 10% monthly payments will result in collection processing

I have read thoroughly and agree to abide by the above Payment Policy

Patient Name (printed)**:**_____ Signature:_____

Date_____

2023 Notice of Privacy Practices

Privacy Officer: Dr. Josh Davis

NAME: _____

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment**.**

Acknowledgement of Physical Therapy Diagnosis

A Physical Therapy diagnosis is NOT a medical diagnosis by a physician or based on radiological imaging, and such services might not be covered by health plan insurance.

I have read thoroughly and agree to Notice of Private Practices and Acknowledgement of Physical Therapy diagnosis

Patient Name (printed)**:** _____ Signature: _____

Date_____

2023 Pictures, Video, and Testimonials

First Step Physical Therapy is exceptionally trained to assist you with your individual recovery program. Your success is our focus. Documentation of your progress is necessary for continued physician referral and for third party reimbursement. Taking pictures and video during your evaluation will establish a baseline to measure your functional achievements. Pictures and videos taken throughout your treatment will document your progress.

In pursuit of HIPAA compliance and with full respect of your privacy,

Please circle YES or NO below:

YES NO I agree with the use of my pictures, video, and testimonials for physician, insurance, educational and research purposes.

YES NO I agree with the use of my pictures and testimonials for display inside **First Step Physical Therapy**

YES NO I agree that my pictures and testimonials may be provided to inquiring persons.

YES NO I agree with the use of my pictures, video, and testimonials for the **First Step Physical Therapy** website and social media pages (Facebook, Instagram, Twitter, Google and Linkedin etc.)

Patient Name (printed)**:** _____ Signature: _____

Date: _____

2023 HIPAA Authorize release of Medical Records

NAME: _____

PLEASE LIST ANY INSURANCE COMPANIES AND/OR HEALTH CARE PROVIDERS THAT YOU WOULD LIKE TO AUTHORIZE RELEASE OF YOUR MEDICAL RECORDS

I Authorize **First Step Physical Therapy** to release pertinent clinical and account information to the following insurance companies to facilitate my reimbursement:

1. _____
2. _____

I authorize **First Step Physical Therapy** to release pertinent clinical and account information to the following **Health Care Providers.**

1. _____
2. _____
3. _____
4. _____

I authorize **First Step Physical Therapy** to release pertinent clinical and account information to the following **family members/caretakers/others.**

1. _____
2. _____
3. _____
4. _____
5. _____

Patient Name (printed)**:** _____ Signature: _____

Date: _____

2023 Medicaid Permissions

ONLY FILL OUT THE BELOW FORM IF YOU ARE THE PATIENT (18+) OR ARE THE PARENT/LEGAL GUARDIAN(S) (UNDER 18) WHO IS ENROLLED IN THE CHILDREN'S INTERVENTION SERVICES (CIS) PROGRAM

Patient Name:_____

I (Print name of parent/legal guardian)_____
hereby authorize **First Step Physical Therapy** to evaluate, as well as provide any subsequent treatment based on the evaluation results for Physical Therapy for child named above.

Signature of Parent/Legal Guardian if minor (printed)**:** _____

Date signed by Parent/Legal Guardian: _____

Relationship to Member: _____

Signature of Therapist or Representative of First Step Physical Therapy**:**

_____Please circle YES or NO below:

YES NO Does your child have an IEP (Individualized Education Program)?
If yes, what was the date it was signed? _____

- **Please provide a copy of the signed and dated IEP.**

If no, explain why:
_____
_____

YES NO Does your child have an IFSP (Individual Family Service Plan)?

If yes, what was the date it was signed? _____