2024 Patient Information

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

Patient Name: _____ DOB:_____

Parent/Guardian Name(s) _____

SSN: _____

Address: _____ City: _____

State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Do you have a Power of Attorney?

Please Circle One: YES NO
IF YES:
Name of Power of Attorney: _____ Phone: _____

Are you a current patient of Home Health (Nursing, Physical Therapy, Occupational Therapy, Speech Therapy, Catheter Care, Wound Care, Etc)?
An active home health case will result in ***non-coverage for outpatient physical therapy***

Please Circle One: YES NO
IF YES:
COMPANY: _____ PHONE: _____

ANTICIPATED DISCHARGE DATE: _____

1. Accepted methods of payment are cash, check, HSA, credit and debit cards (Visa, Master Card, Discover, American Express.)
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. Co-pays, coinsurances and out of pocket payments are due at the time of service.
5. Invoices for services will be mailed at 30 and 60 days. Once a balances has matured to 90 days the policy is as follows:
    - Suspension of services
    - Minimum monthly payment of 10% of the remaining balance is required until the account is paid in full.
    - Failure to make minimum payments will result in collection processing.

RESPONSIBILITY AT TIME OF SERVICE

$_____

I have been informed of my responsibility at the time of service for my appointments at First Step Physical Therapy. I understand that this is a quoted amount subject to change based on my insurance benefits and that it is my responsibility to understand those benefits.

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 or no call no show
    - Patients that are **15-30 minutes late** will accumulate a **$25 late fee**
    - Over 30 minutes late to an appointment will be considered a no show
    - 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

I have read thoroughly and agree to abide by the First Step Physical Therapy's Payment Policy and Cancellation policies

Patient Name (printed)**:** _____

Signature: _____ Date: _____

PAYMENT AUTHORIZATION FORM

This card will **ONLY** be used for the **cancellation fee and late fee** as stated above, unless otherwise specified. With a doctor's note, school note and/or accepted extenuating circumstance there will be no charge.

Please circle one below

YES, I authorize this credit card to be used for my regular payments due at the date of service.

NO, do **not** I authorize this credit card to be used for my regular payments due at the date of service.

Credit Card Information		
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX		**HSA? ☐ Yes ☐ No**
Cardholder Name (as shown on card):		
Card Number:		
Expiration Date (mm/yy):	**CVV Code:**	**Cardholder billing ZIP Code:**

I have read thoroughly and understand thePayment authorization form

Patient Name (printed)**:** _____

Signature: _____ Date: _____

2024 PRIVACY POLICY

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. I may request a copy of any amended Notice of Privacy Practices at each appointment**.**

Acknowledgment 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.

Pictures, Video, and Testimonials

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

Please circle YES or NO below:

YES NO I agree with the use of my pictures, video, and testimonials for physicians, 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 **First Step Physical Therapy** can share general updates, testimonials, and images with individuals who inquire about me or my treatment, past or present

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, TikTok, Google Linkedin, etc.)

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

Patient Name (printed)**:** _____

Signature: _____ Date: _____

2024 HIPAA Authorize Release of Medical Records

Please list below any entities or individuals you would like to give us, First Step Physical Therapy, permission to share your protected health information with. Under HIPAA law we as providers cannot disclose any information about our patients without explicit permission from you, the patient.

Friends, Family, Caregivers, etc.

1. Name: _____ Relation _____
2. Name: _____ Relation _____
3. Name: _____ Relation _____

Doctors Offices

1. Group/Location: _____

   Practitioner: _____

   Phone: _____ Fax: _____

2. Group/Location: _____

   Practitioner: _____

   Phone: _____ Fax: _____

3. Group/Location: _____

   Practitioner: _____

   Phone: _____ Fax: _____

I understand that I am permitting First Step Physical Therapy to discuss my protected health information with the above-listed entities.

Patient Name (printed)**:** _____

Signature: _____ Date:_____