First Step
PHYSICAL THERAPY

2019 PATIENT INFORMATION

Welcome to **First Step Physical Therapy!** Thank you for selecting our practice for your physical therapy needs.
In order to serve you properly, we will need the following information.

PATIENT NAME: _____DATE:_____

IF Patient is a CHILD, PARENT/GUARDIAN'S NAME(S): _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME#: _____ CELL#: _____ WORK#: _____

EMAIL ADDRESS:_____ DATE OF BIRTH: _____ SSN#: _____

REFERRING PHYSICIAN: _____ PHONE#: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

IN CASE OF AN EMERGENCY, PLEASE PROVIDE THE FOLLOWING INFORMATION

NAME:_____ PHONE#: _____ RELATIONSHIP: _____

NAME:_____ PHONE#: _____ RELATIONSHIP: _____

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2019 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, we request **at least 24 hour notice** when you must cancel your scheduled appointments.

All persons are given a "3 Strike" ruling.
You do not need an excuse for your first 3 Late Cancellations.
You will NOT be charged for your first 3 Late Cancellations.

Our Cancellation Policy is reserved for the highly rare occurrence of a 4th Late Cancellation.

There is a charge of $90 per hour cancellation fee for appointments cancelled with less than 24 hours' notice.
Persons who have a 4th Late Cancellation will not be allowed to schedule more than 2 weeks in advance.

Cancellation fees will be excused with a signed medical doctor's note on their professional letterhead or prescription pad.

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

PATIENT NAME (printed): _____

SIGNATUREOF RESPONSIBLE PARTY _____

Relationship to Patient_____

PRINT NAME _____DATE_____
(If other than Patient)

WITNESS_____
Revised 1/02/19

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2019 PAYMENT AND FEE POLICY

Thank you for choosing First Step Physical Therapy. Your symptom recovery is our highest priority. It is important to us that you fully understand our payment policy. Please read thoroughly and feel free to ask any questions about your payment responsibilities. All business forms are required to be signed and dated prior to any services rendered in 2018.

Physical Therapy Evaluation and Re-Evaluation Hour	**$210**
Physical Therapy Treatment Hour	**$185**

1. Methods of payment are cash, check, Visa, Master Card, Discover, and American Express.
2. A $50 fee is charged for all checks that are returned due to insufficient funds.
3. A Processing fee of 4% will be added to all credit transactions.
4. For Non-Medicare patients, First Step Physical Therapy does offer an incentive to patients who are able to pay for Physical Therapy treatment hours at the time of service. This 'SAME DAY PAYMENT DISCOUNT' is $25 off of each Physical Therapy treatment hour paid in full at the time of service. This incentive does not apply to Physical Therapy Medicare patients. It also no longer applies to hours with Dr. Sue Leger and Dr. Josh Davis.
5. All Persons are required to pay their plan's designated co pay upon date of service.
6. All patient accounts with unpaid services reaching 90 days past date of services will be handled as follows:
   a. All scheduling of services will be immediately suspended.
   b. Immediate payment of a minimum of ten percent of total amount due will be required.
   c. Subsequent monthly payments of a minimum of ten percent of remaining balance will be required until account is paid in full.
   d. Failure to comply will result in collection processing.

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

PATIENT NAME (printed):_____

SIGNATUREOF RESPONSIBLE PARTY:_____

Relationship to Patient:_____

PRINT NAME: _____DATE_____
(If other than Patient)

WITNESS:_____

Revised 1/02/19

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2019 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 still pictures and video during your evaluation will establish a baseline to measure your functional achievements. Pictures and video taken throughout your treatment regime will document your progress.

In pursuit of HIPPA compliance and with full respect of your privacy, please consider the options and clearly circle 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 displayed inside **First Step Physical Therapy**.

YES NO I agree that my pictures, video, 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, such as, Facebook, Instagram, Twitter, LinkedIn, etc.

PATIENT NAME (printed):_____

SIGNATUREOF RESPONSIBLE PARTY:_____

Relationship to Patient:_____

PRINT NAME: _____DATE_____
(If other than Patient)

WITNESS:_____
Revised 12/19/18

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2019 Notice of Privacy Practices

Privacy Officer: Josh Davis

NAME OF PATIENT: _____

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.

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 or insurance."

PATIENT NAME (printed):_____

SIGNATUREOF RESPONSIBLE PARTY:_____

Relationship to Patient:_____

PRINT NAME:_____DATE:_____
(If other than Patient)

WITNESS:_____

Revised 1/02/19

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2019 HIPAA AUTHORIZE RELEASE OF YOUR MEDICAL RECORDS

NAME OF PATIENT: _____

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

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

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

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

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

PATIENT NAME (printed):_____

SIGNATUREOF RESPONSIBLE PARTY:_____

Relationship to Patient:_____

PRINT NAME:_____DATE:_____
(If other than Patient)

WITNESS:_____

Revised 1/02/19

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Patient Intake Information

_____	_____	_____
Patient Name	**Current Age**	**Date of Evaluation**

Please complete the following information. This will assist us in designing the most effective and efficient individualized program for you. Every Item is significant and important. Thank you.

Who recommended you to this office_____

Diagnosis/Main Problem:_____

Surgery Performed: ☐ Yes ☐ No_____

Prior Hospitalization: ☐ Yes ☐ No_____

Please list below the main complaints/challenges you have in order of their importance:

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

PAIN:

Location(s) of Current pain:_____

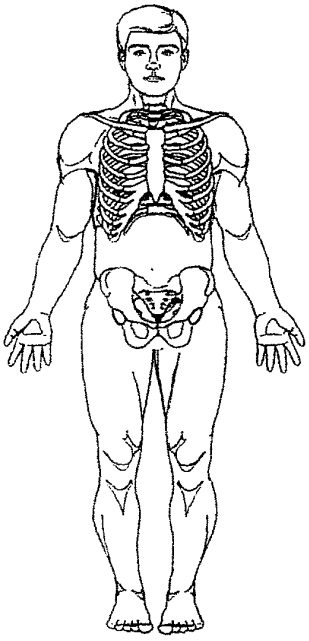
What makes your pain worse_____

What makes your pain better?_____

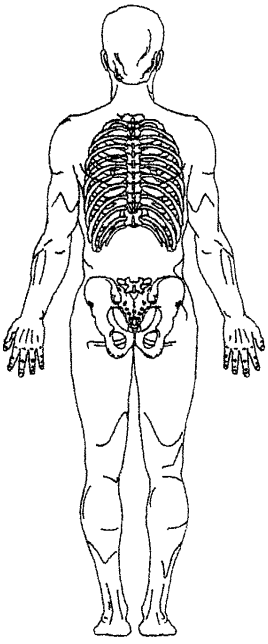
Pain Diagram:

Please shade in all areas of pain.

Front



Back



Medical History:

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Previous History of Similar Injury: ☐ Yes ☐ No

Are you a current patient of Home Health Care: ☐ Yes ☐ No

History of Falls: ☐ Yes ☐ No

Diagnostic Test/Imaging (X-ray, MRI, CT, etc): ☐ Yes ☐ No _____

Unexplained Weight Loss ☐ Yes ☐ No

Please Check all that apply:

☐ Osteoarthritis

☐ Cardiovascular Disease

☐ Diabetes

☐ Allergies

☐Surgical History _____

☐Previous Physical Therapy_____

☐History of Cancer_____

☐ Current Infection

☐ Immunosuppression

☐ Fracture

☐ Cauda Equina Syndrome

☐ Other _____

☐ Diagnostic Test/Imaging (X-ray, MRI, CT, etc)_____

Unexplained Weight Loss ☐ Yes ☐ No

Current Medications:

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Please List any prescribed medication, over the counter medication, and/or supplements you are taking:

Name of Medication/Supplement	Dosage	How long have you taken medication/supplement?

Are you seeing any other doctors or health care professionals now for any reason? ☐ Yes ☐ No

Practitioner's Name	Type of Practitioner:	Phone Number or Address:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you want us to send out an evaluation note to these practitioners? ☐ Yes ☐ No

Physical Therapy Goals:

1._____

2._____

3._____

4._____

5._____