American Specialty Health (ASH)
P.O. Box 509077, San Diego, CA 92150-9077

INITIAL HEALTH STATUS

PT OT ST AT Fax: 877.248.2746

Patient Name_____ Subscriber ID #_____ Primary Language_____

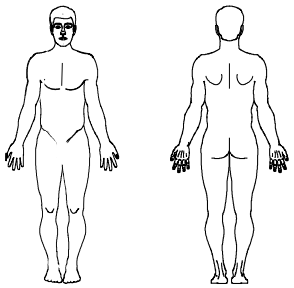
Describe Your Current Problem and How It Began_____

_____

_____

Onset date/Surgery date_____

Indicate below where you have pain or other symptoms



Is this? ☐ Work Related ☐ Auto Related ☐ N/A

How often are your symptoms present?

☐ Constantly (76-100% of the day) ☐ Occasionally (26-50% of the day)
☐ Frequently (51-75% of the day) ☐ Intermittently (0-25% of the day)

Describe the nature of your pain:

☐ Sharp ☐ Dull Ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling

How is your condition changing?

☐ Getting Better ☐ Not Changing ☐ Getting Worse

Current complaint (how you feel today):

No pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

In the past week, how much has your pain interfered with your daily activities (e.g., work, social activities, or household chores)?

No interference 0 1 2 3 4 5 6 7 8 9 10 Unable to carry on any activities

Check if you have difficulty: ☐ Seeing ☐ Hearing ☐ Talking ☐ Memory ☐ Swallowing

What is your most effective learning method: ☐ Seeing ☐ Hearing ☐ Talking ☐ Doing ☐ Pictures

In general would you say your overall health right now is:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Have you had x-rays, MRI, CT Scan for your area(s) of complaint? ☐ Yes ☐ No

Date(s) taken_____ **What areas were taken?**_____

Please check all of the following that apply to you:

☐ Alcohol/Drug Dependence
☐ Recent Fever
☐ Diabetes
☐ High Blood Pressure
☐ Cardiac Condition
☐ Stroke (Date)_____
☐ Dizziness/Fainting
☐ Cancer/Tumor (Explain)_____
_____
☐ Osteoporosis
☐ Other Health Problems (Explain)_____
_____

☐ Numbness (Location)_____
☐ Urinary Problems
☐ Currently Pregnant, # Weeks_____
☐ Abnormal Weight ☐ Gain ☐ Loss
☐ Pain Unrelieved by Position or Rest
☐ Pain at Night
☐ Surgeries_____
_____
☐ Tobacco Use - Type_____
Frequency_____/Day
☐ Current Medications_____
_____

Who have you seen for your condition before today? ☐ No One

☐ Medical Doctor ☐ Massage Therapist ☐ Chiropractor ☐ Other_____
☐ Physical Therapist ☐ Acupuncturist ☐ Occupational Therapist ☐ Speech Therapist ☐ Athletic Trainer

What treatment did you receive and when?_____

What is your occupation?_____

I certify to the best of my knowledge, the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider/practitioner, I understand that I am liable for all charges for services rendered and I agree to notify this provider/practitioner immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that this provider/practitioner may need to contact my physician if my condition needs to be co-managed. Therefore, I give authorization to this provider/practitioner to contact my physician, if necessary.

Patient/Responsible Party Signature_____ **Date**_____

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SPORTS & PHYSICAL THERAPY
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Consent for Care & Treatment: I agree and give consent for medical care and treatment to _____ _____ as considered medically necessary in evaluating and treating my/his/her physical condition..

Patient/Guardian/Responsible Party _____ **Date** _____

Benefit Assignment/Release of Information: I agree to assign all medical benefits to which I am entitled to Given Sports & Physical Therapy, PC for services rendered. I hereby authorize release of all information necessary to secure payment for these services.

Patient/Guardian/Responsible Party _____ **Date** _____

Financial Policy Explanation

- Proper identification is needed at the time of the initial evaluation.
- Accurate insurance and injury information must be presented by the patient.
- If benefits are subsequently denied by an insurance company, the patient is fully responsible for the charge of rendered services.
- Although benefits and coverage are verified prior to therapy, the patient is fully responsible to understand their individual benefits. Pre-verification of benefits/coverage is only an estimate of coverage and not a guarantee of benefits.
- Patients under the age of 18 years old require signed consent from a parent/guardian.
- Patients should be aware that some insurance plans require specific pre-authorization or HMO referral for physical therapy.
- If an insurance carrier does not remit payment within 120 days, the balance shall be considered patient responsibility at that time.
- Pre-collection notices will be sent after the same patient balance is billed on two consecutive occasions. Patients will be responsible for all costs of collecting monies including court costs, additional collection agency fees, and attorney fees incurred
- A $25 charge will be assessed for any dishonored/returned check or any failed payment plan transaction.
- Medical supplies – payment is due in full at the time of receipt as these are not billed to any insurer; payment for medical goods is non-refundable

Commercial Insurance:

- Co-payments: Without exception, insurance companies require that co-payments be paid at the time of service.
- Co-insurances and deductibles: Estimated co-insurance and deductible payments are due at the time of service. After an EOB is received from the insurance company, any remaining balance will be billed to the patient.
- Any refund due to the patient will be credited to the account or a refund check will be issued once all insurance payments are received.

Medicare: Claims will be submitted to Medicare and any supplementary/secondary plan. Clients are urged to speak directly to the therapist about the implications of calendar year caps on Medicare services. Clients need to notify this office if any home health therapy or nursing services have just concluded or continue.

Medicaid: Medicaid limits therapy services to 20 visits/contract year for adults. Clients should notify the therapist of any other therapy services in the contract year.

Workers' Compensation: Case managers/adjusters will be notified of missed appointments.

Auto/Personal Injury: The client may 1) elect to self-pay for services or 2) elect that this office bills their personal health or auto insurance. Personal health insurance shall be considered a secondary payor to auto insurance. No 3rd party billing is allowed.

Self-pay: Payment is due at the time of service at the lesser of billed charges or $125 per treatment session.

Patient/Guardian/Responsible Party _____ **Date** _____

407 E. Terra Cotta Avenue, Suite E • Crystal Lake, IL 60014 • (815) 477-8004 • Fax: (815) 477-8005 givensportspt@att.net • www.givensportspt.com

Attendance Policy

You have the right to choose where you attend physical therapy. As a private practice clinic independent of any direct ties to referral sources or hospital networks, we thank you for your decision to attend therapy at **Given Sports & Physical Therapy, P.C.**

Positive clinical outcomes and customer satisfaction are the measures of our success. Compliance with your prescribed frequency of physical therapy and suggested home exercise program is a vital component of your progress with our services. Please realize that your schedule affects not only our staff but also other patients. Our commitment to your progress is reflected in the following attendance policy.

Our policy includes the following steps:

1. We have extended times beyond those typical for a medical facility as a means of accommodating the needs of our patients.
2. We will give you a verbal and/or written schedule of your appointments.
3. If you need to cancel an appointment, please do so one or more days prior to your scheduled visit.
4. If you need to reschedule an appointment, please call our office and we will make every effort to do the same day or later in the week in order to keep your prescribed frequency of therapy.
5. In the event of a missed appointment, you will receive a phone call from our office (usually within 15 minutes of your scheduled appointment time). We will attempt to reschedule the missed appointment to another time during the week.
6. If we are unable to reschedule your missed appointment during the same week of therapy, we reserve the right to charge you a fee of ***$25***. This fee will not be charged to your insurance. Instead, we ask the fee be paid at your next appointment.
7. Your referring physician will be notified of your attendance and compliance with therapy. If you are a patient with workers' compensation insurance, we are obligated to immediately notify your adjuster or case manager of any scheduling issues.

We understand that serious emergencies and last minute changes in your daily schedule can happen. We simply ask for a courtesy call to inform us if such a event occurs. In instances of repeated non-compliance with your scheduled visits, we reserve the right to discontinue care and will notify your physician of this reason.

Again, we sincerely appreciate your decision to begin treatment at **Given Sports & Physical Therapy, P.C**. and wish you well in your rehabilitation!

I have read and understand this policy:_____ Date:_____

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We are committed to providing quality healthcare services to you. An important part of that is facilitating various privacy rights that you have under Federal Law.

This document serves 2 purposes:

1. Acknowledgment by signature that the Notice of Privacy Practices has been made available for review. Signature indicates understanding and agreement with said Notice.
2. Instructions to request any restriction pertaining to the uses and disclosures of your protected health information ("PHI") that we may make for treatment, payment and operational reasons, as well as for other reasons provided for under applicable law.

Notice of Privacy Practices:

I understand the Notice of Privacy Practices (posted at www.givensportspt.com and available for review in the clinic itself) and consent to disclosure for permitted uses. I fully understand the terms of consent.

Patient Name: _____ **Date of Birth:** _____

Patient/Legal Representative Signature: _____ **Date:** _____

Restriction Request

Describe the PHI that you would like restricted including any individual(s), provider(s), insurance company(s) and/or other organization(s) that you would like to *prevent* from reviewing the designated PHI.

Detailed Description of restricted information: _____

Persons or Organizations Restricted: _____

It is our policy to process restriction requests within thirty days (30) of receipt. We will use the contact info that we have on file to: 1) follow-up with you for additional information if necessary; and/or 2) send you our written response to your request.

Patient Name: _____ **Date of Birth:** _____

Patient/Legal Representative Signature: _____ **Date:** _____

Authorization

Given Sports & Physical Therapy may release information regarding my treatment to the following individuals:

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

Patient Name: _____ **Date of Birth:** _____

Patient/Legal Representative Signature: _____ **Date:** _____

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