CC's Physical Therapy

PATIENT INFORMATION

Name:_____ Birthdate: _____ Age:_____

Address: _____
Street *City* *State* *Zip code*

Male _____ Female _____ Single ____ Married ____ Separated ____ Divorced ____Widowed_____

Occupation: _____ Employed by: _____

Primary Phone: (____)_____ (CELL or HOME) Email: _____

Appointment Reminder Message Type (Please circle preferred): CALL TEXT No Reminder

Emergency Contact:_____ _____ (____)_____
Name *Relationship to patient* *Contact Number*

How did you hear about us? _____ Name of person: _____

Please check &/or describe any of the conditions below that apply to your past & current medical history:

- ☐ Diabetes
  - ☐ Type I
  - ☐ Type 2
- ☐ Implanted Medical Device
  - ☐ Pacemaker
  - ☐ Defibrillator
  - ☐ Pain stimulator
- ☐ Blood Thinner/ Anticoagulant
  Type: _____
  Last known INR:_____
- ☐ Depression/Anxiety
  - ☐ Current
  - ☐ History
- ☐ Breast Implants
  - ☐ Current
  - ☐ Previously
- ☐ Body Piercings
  (**OTHER than on head, nose, ears, tongue**)
  Location: _____
- ☐ Cancer
  - ☐ Active
  - ☐ Remission
- ☐ Infectious Disease
  (transmitted through blood or bodily fluids)
  - ☐ Hep A
  - ☐ Hep B
  - ☐ Hep C
  - ☐ HIV
  - ☐ Other

What brought you here TODAY?

Please list what body part/parts prompted your appointment today: _____

If more than one body part, which is your chief complaint **today**?: _____

When did your current symptoms begin? _____

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INFORMED CONSENT FOR PHYSICAL THERAPY

The above information is true to the best of my knowledge. I hereby assign all medical benefits for which I am entitled to CC's Physical Therapy in the event they file insurance claims on my behalf. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of CC's Physical Therapy for my condition as described by the North Dakota PT Practice Act. I understand I have the right to ask my attending physical therapist about the potential risks and benefits of recommended treatment interventions. This consent is intended as a waiver of liability for such treatment except in acts of negligence. I acknowledge that my treatment program has been explained by CC's, and all my questions have been answered to my satisfaction. I understand the risks associated with a program of physical therapy as outlined to me, and I wish to proceed.

_____
Patient Printed Name

_____ _____
Patient Signature (Guardian if < 18) Date

NO SHOW POLICY

Definition of a "No-Show" Appointment:
CC's Physical Therapy defines a "No-Show" appointment as any scheduled appointment in which the patient either:

1) Does not arrive to the appointment, 2) cancels with less than a 2 hour notice, or 3) arrives more than 15 minutes late and is consequently unable to be seen

Consequences of "No-Show" Appointments:
For every no-show the patient has, they will **automatically be billed a $35 fee** for each date of service that the no-show occurred. If the patient continues to no-show at least three times, the patient will only be allowed to schedule same day appointments. If no shows continue to happen after that, the patient may be dismissed from CC's Physical Therapy at the discretion of your Physical Therapist.

Tobacco & Substances: You agree not to use tobacco products at our facility. Also, you agree not to arrive at appointments under the influence of alcohol or unprescribed controlled substances. If you fail to comply with the foregoing, we have the right to refuse service and to assess a $35 no-show charge (which is not covered by insurance benefits).

I have read and understand the CC's Physical Therapy "No-Show" Policy as described above. Initial:_____

CC's Physical Therapy

NOTICE OF PATIENT INFORMATION PRACTICES

Effective January 1, 2021

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

CC's Physical Therapy Legal Duty:
CC's is required by law, to maintain the privacy of protected health information, to provide you with notice of its legal duties and privacy practices with respect to protected health information, to abide by the terms of the notice currently in effect, and to notify affected individuals following a breach of unsecured protected health information.

Uses and Disclosures of Health Information
CC's uses your personal health information primarily for treatment, obtaining payment of treatment, and conducting internal administrative activities. For example we may use your personal health information to contact you to provide appointment reminders, to contact health insurance providers to obtain payment for services, and to communicate among CC's personnel to develop effective treatment plans or evaluate the quality of the care provided to you.

CC's may also use or disclose your personal health information without prior authorization as required and permitted by law including for public health purposes, auditing purposes, and emergencies. We may provide de-identified information for research studies. Other uses and disclosures not described in this notice will be made only with your written authorization, and if you grant written authorization you may later revoke that authorization to stop future disclosures at any time.

CC's may change its policy at any time. When changes are made the updated notice will be posted in a common area of our office and on our website. You may also request an updated copy of the practices at any time.

Patient's Rights
You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes. If you have agreed to receive this notice electronically, you have the right to obtain a paper copy of this notice upon request.

Concerns and Complaints
If you believe your privacy rights have been violated, you may complain to CC's and to the US Department of Health and Human Services. To submit a complaint to CC's, please contact the company owner, April Mettler, at 701-751-0994 or submit the complaint in writing to CC's. You will not be retaliated against for filing a complaint.

I have read and am in agreement of the above policies and have received a copy of the Notice of Patient Information Practices. I consent to the use and disclosure of my personal health information for purposes as noted in the Notice of Patient Information Practices. I understand I retain the right to revoke this consent by notifying the Company in writing at any time.

_____ _____

Patient Signature (Guardian if < 18) Date

CC's Physical Therapy

FINANCIAL POLICY STATEMENT

We bill your insurance carrier as a courtesy to you. If your insurance carrier denies payment, the balance will be due in full from you in a timely fashion unless reason for denial is due to an error on behalf of CC's Physical Therapy, LLC. If any payment from your insurance carrier is made directly to you for services billed by us, you recognize an obligation to promptly submit payment to CC's Physical Therapy.

High Deductible Plans
According to benefit verification, you owe _____ of your _____ deductible. Therefore, you will be responsible for 100% of medical costs billed by CC's Physical Therapy until the full deductible amount is met.

Payment Plan Option:
A down payment plan is suggested at the rate of ***$85*** *for your initial evaluation and* ***$50*** *for each follow up visit*. Any remaining balance after the down payment is made will be billed out each month as the amounts of this payment plan will likely not cover the entire cost of your treatment. If you choose to utilize our down payment plan for services rendered at CC's Physical Therapy, consistent and regular payments must be made as agreed upon with the billing manager.

I would like to utilize CC's Payment Plan Option. Initial:_____

Pay in Full Option:
If you choose to forgo the suggested payment plan, payment of your ***balance in FULL will be expected upon receipt of your monthly statement***.

I would like to pay my bill in full upon receiving monthly statements. Initial:_____

WSI
The above may not apply for those patients that are considered Worker's Compensation. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you. CCs Physical Therapy will appeal Worker's Compensation denials one time in an attempt to reverse the decision. In the event an appeal is denied, it is the full responsibility of the patient to remit payment. ***Initial:_____***

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees. Interest to be applied to all outstanding balances not actively being paid on as made in agreement between the patient and CC's Physical Therapy at an annual rate of 18%.

_____ _____
Patient Signature (Guardian if < 18) Date

CC's Physical Therapy

Patient Name: _____

Date of Birth: _____

MEDICATION/SUPPLEMENT	DOSAGE	ROUTE	FREQUENCY
Ex. Advil/Ibuprofen	*100 mg/2 pills*	*By mouth*	*2x/day*
Ex. Magnesium	*200 mg/2 tablets*	*By mouth*	*1x/day*
Ex. Lovenox	*40 mg/.4 ml*	*Subcutaneously/injection*	*1x/day*
Please enter all medications (prescription OR over the counter) and supplements you are **currently** taking below. Follow the examples above for one per line:			