PRO Therapy, Inc.
Patient Health Information

Name: _____ **Date:** _____ Age: _____
Place of Work:_____
Who Referred you to Physical Therapy? _____
Name:
Date last seen by physician? _____ What problem are you seeking Physical Therapy treatment for?_____ When did the problem begin?_____ Have you ever had this problem before? Yes____ No____
If yes, what did you do for the problem?_____ Did it improve? Yes____ No____
What makes the problem worse?_____ What are your goals for Physical Therapy?_____

Living Environment

Does our home have:	Stairs, no railing___	Stairs with railing___	Ramps_____
	Elevator_____	Uneven terrain_____	Obstacles_____
Do you live in a:	Private home_____	Assisted living_____	Apartment_____

General Health Status

Height_____ Weight_____
Please rate your health: Good____ Excellent_____ Fair_____ Poor_____
Smoking: Currently smoke tobacco? Yes____ No____. If yes, how many packs per day?_____
Cigars/Pipes per day? _____ Smoked in the past? Yes____ No____. Year Quit_____
Alcohol: Yes____ No____. If yes, how many days per week do you drink alcoholic beverages? _____
Exercise: Do you exercise beyond normal daily activities and chores? Yes____ No____. If yes, how many days per week do you exercise or do physical activity?_____ For how many minutes on average?_____

Medical/Surgical History

Please check if you have ever had any of the following:

Arthritis ☐	Kidney Problems ☐
Broken bones/Fractures ☐	Recurrent Infections ☐
Osteoporosis ☐	Cancer ☐
Blood Disorders ☐	TB/Hepatitis ☐
Circulation/Vascular Problems ☐	Stomach Problems ☐
Heart Problems ☐	Skin Diseases ☐
High Blood Pressure ☐	Depression ☐
Lung Problems ☐	Headaches ☐
Stroke ☐	Vision Problems ☐
Diabetes/High blood sugar ☐	Heart Attack ☐
Low blood sugar ☐	Pacemaker ☐
Head Injury ☐	Occupation: _____
Multiple Sclerosis ☐	Allergies _____
Muscular Dystrophy ☐	_____
Parkinson's Disease ☐	
Seizures/Epilepsy ☐	
Growth Problems ☐	Have you ever had surgery? Yes____ No ____. If Yes, please describe
Thyroid Problems ☐	and include dates:_____
	_____

PRO Therapy
Financial Policy

TO OUR VALUED PATIENTS:

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive you maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due on each visit for charges incurred through your last visit. All copayments are expected at time of service. We accept cash, checks, and all major credit cards. There is a service charge for insufficient funds.

Please read carefully:

1. Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract. We bill your insurance as a courtesy to you. We must emphasize that our relationship is with you, our patient, not your insurance company. It is the policy of PRO Therapy to comply with all terms and conditions of our insurance contracts.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility. We will do everything on our part to verify benefits on your behalf, but ultimately, you are responsible for your own insurance benefit verification.
3. You are expected to pay your deductible and/or co-insurance applied by your insurance carrier. If payment from your insurance company is not received within 90 days from the date of service, you will be expected to pay the balance in full. Patients with an outstanding balance of 60 days overdue must make payment arrangements prior to scheduling future appointments.
4. Our fees are considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 80%) of usual, customary, and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard and cost of care in this area.
5. If this injury is work related, and a Workers Compensation claim has been initiated we require on your initial visit that you provide us with your medical insurance to insure payment of the account if your case is not allowed. If you already have a claim number, please provide us with the number, billing address, and adjusters contact information on the registration form. Our office does not bill to third parties.
6. Our office requires a 24-hour notice for cancellation of appointments; you can call and leave a message on the answering machine if needed. We realize conflicts with work, other activities, or unexpected illness may require you to call and reschedule, however, there will be a $25.00 charge for a missed appointment without notification to the office.

Again, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. It is PRO Therapy's policy to have the right to adjust specific out of pocket expenses in order to provide our patients the care they need within their financial ability to pay. If such problems do arise, we encourage you to contact us promptly for assistance. A patient must indicate, in writing, a reason for inability to pay and then the terms of agreement can be negotiated. Each case will be valid only for the term of the physician script and will be re-evaluated on a case by case basis.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you!I have read the above policies and agree. I further agree to assign insurance benefits to be paid directly to PRO Therapy and that I am responsible for non-covered services

.**SIGNATURE: _____DATE: _____**

PRO Therapy, Inc.

Patient Bill of Rights

As a patient, family member, or responsible guardian, you have the right to:

- Be fully informed verbally and in writing of your rights before treatment.
- Care regardless of race, color, creed, sex, or national origin.
- Be free of verbal, physical, and psychological abuse.
- Refuse treatment and be informed of the consequences of this action.
- Exercise any of these rights as a patient of this agency.
- Receive the highest quality of care.
- Be treated with respect and dignity to yourself and your property.
- Be referred to an alternative service if the agency is unable to provide necessary care or for any reason denies service to you.
- Voice grievances regarding treatment or care or lack of respect for property without discrimination or reprisal for voicing those grievances.
- Participate in planning your care and treatment or any changes in your care.
- Be informed in advance of any changes in the plan of care before being made.
- Receive appropriate instruction and education regarding your care plan.
- Be informed in the disciplines of physical therapy and the frequency of proposed visits.
- Confidentiality of your clinical records and be informed of the agency's policy regarding the disclosure of your clinical records for any purpose.
- Review your clinical records unless contraindicated by the physician.
- Be advised in advance the extent to which payment for services may be expected from you. Patient liability will be the balance of the bill remaining after filing insurance claims with Medicare and Secondary insurances.
- Be informed of any changes in the payment for services within 15 days.
- Be informed of charges or services not covered by Medicare or any federally funded
- programs or insurance.
- Have access to all bills for services.

- Have received and read PRO Therapy, Inc.'s Notice of Privacy Practices as posted, or upon request.

Patient Signature_____ Date_____

PRO Therapy, Inc.

INFORMED CONSENT FOR PHYSICAL THERAPY

Dear Patient:

Physical Therapy involves the use of many different types of physical evaluation and treatment. At PRO Therapy, we use a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy. Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time before or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

I acknowledge that my treatment program has been explained by PRO Therapy, and all of 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's Printed Name Signature

Date_____

EMERGENCY CONTACT Name & Number _____

APPENDIX F

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, **PRO Therapy** (The Company) creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among The Company's personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill.
I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for The Company that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that The Company may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that The Company is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of PRO Therapy and agree to the liability limitations explained therein.

Signature of patient or legal representative	Date	Relationship to Patient

Printed name of patient
Effective date April 14, 2003
Revised date September 23, 2013