ABSOLUTE
Physical Therapy Inc.

How did you come to know of Absolute Physical Therapy?

◯ ***Insurance List/Referral*** ◯ ***Physician Referral*** ◯ ***Storefront Sign*** ◯ ***Other_____***

PATIENT INFORMATION

Name: _____ ***Birth date:*** _____ ***Home Phone:*** _____

Social Security: _____ ***Address:*** _____

City: _____ ***State:*** Alabama ***Zip:*** _____ ***Sex: M F Marital Status: M S W D Sep***

Employer Name: _____ ***Status: FT PT Student Work Phone:*** _____

In an emergency please contact: _____ ***Phone:*** _____ ***Relationship:*** _____

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Absolute Physical Therapy Inc. to release any information acquired in the course of my examination or treatment to my doctor and my insurance company only.

_____ _____ _____

Patient or Legal Guardian's Signature ***Witness*** ***Date***

FINANCIAL AGREEMENT

I hereby authorize payment of medical benefits directly to Absolute Physical Therapy Inc. and I understand that I am financially responsible for the charges not covered by this authorization or in the event of an industrial denial.

_____ _____ _____

Patient or Legal Guardian's Signature ***Witness*** ***Date***

3120 E. Union Hills Drive, Suite 202, Phoenix, AZ 85050
Phone: (602) 867-2121 Fax: (602) 867-2424 *AbsolutePT.com*

ABSOLUTE
Physical Therapy Inc.

MEDICAL ASSIGNMENT OF BENEFITS & FINANCIAL POLICY

PLEASE READ, SIGN AND DATE

We at **Absolute Physical Therapy Inc.** are pleased to be a part of your rehabilitation experience and thank you for choosing us. We find that communication with our patients regarding our financial policy assists in providing the best service to you.

INSURANCE BILLING

We will gladly call your insurance company to identify what your benefit plan is, however, please understand that insurance companies will not guarantee medical benefits over the phone. **Because it is ultimately your responsibility, we strongly encourage you to consult your benefits book or contact your insurance company directly, in order to understand your plan's coverage and limitations.** We can only use this information, as an estimated **guideline** in order to collect what your insurance company says is your "out-of-pocket responsibility." Actual determination is made 4 to 8 weeks later, after we receive the written notification and/or payments on your claim. If your insurance company makes a determination you do not agree with, it is your responsibility to contact them. Please note that we will only bill up to 2 insurance companies per claim.

Your insurance company may also require a **current prescription (prescriptions expire 30 days from the date they are written)** or pre-authorization from your physician for physical therapy services. Non-compliance with this may result in services not being reimbursed by your insurance company.

PAYMENTS

All deductibles, copays, co-insurance and cash pay estimated amounts are due at the time of service, unless other written arrangements have been made with our facility.

Once we have received all payments or notifications from your insurance company, we will present you with your final statement. Payment for any outstanding balance will be due in full no later than 30 days from the date of your final statement. If we do not receive the payment-in-full 30 days from the date of your final statement, we may be forced to pursue legal collection proceedings and you will be responsible for the 35% collection fee incurred for collection costs.

Please do not hesitate to ask us any questions or request a copy of your account balance. Once again we appreciate your choosing **Absolute Physical Therapy Inc.**

By signing this form, I the patient (or legal guardian of the patient), have read, understood and agree that I am 100 % liable for all fees incurred for services rendered here at **Absolute Physical Therapy Inc.** I also agree to authorize **Absolute Physical Therapy Inc.** to release my medical information to insurance companies, physician(s), attorney(s) and to all other pertinent parties that may be involved in my claim or care and that I agree to assign all payment of benefits to **Absolute Physical Therapy Inc.**
Keep in mind, your recovery period is dependent on whether you keep up with scheduled appointments. You may be subject to a $20.00 charge if you cancel or no show with less than a 24 hour notice.

_____ _____

Patient Name (Printed) **Date**

_____ _____

Patient (or Legal Guardian) Signature **Date**

3120 E. Union Hills Drive, Suite 202, Phoenix, AZ 85050
Phone: (602) 867-2121 Fax: (602) 867-2424 *AbsolutePT.com*

ABSOLUTE
Physical Therapy Inc.

MEDICAL HISTORY

Patient Name: _____
Date: _____

1. Please check if any of the following apply to you. If so, please provide further information.
   - ☐ Allergies _____
   - ☐ Heart Condition _____
   - ☐ Seizure Disorder _____
   - ☐ Diabetes _____
   - ☐ Hypoglycemia _____
   - ☐ Pacemaker _____
   - ☐ Other _____
2. Are you pregnant? _____
3. What are your physical therapy rehabilitation expectations/goals? _____
4. Please list all medications you are currently taking _____
5. Who is your referring physician? _____
6. For industrial/workers' compensation cases only:
   Case Manager: _____ Phone: _____
7. Please list prior surgeries or previous significant injuries
8. Do you have any cardiac/heart condition for which exercise would be inadvisable?

3120 E. Union Hills Drive, Suite 202, Phoenix, AZ 85050
Phone: (602) 867-2121 Fax: (602) 867-2424 *AbsolutePT.com*

ABSOLUTE
Physical Therapy Inc.

AUTHORIZATION FOR TREATMENT

Physical Therapy/Occupational Therapy is a patient care service provided in response to a wide range of medical care needs of outpatients of all ages, regardless of gender, color, race, creed, national origin or disability, five days a week.

The purpose of Physical Therapy/ Occupational Therapy is:

- **To treat disease, injury, and disability by evaluation, examination, testing, and use of rehabilitative procedures, manipulations, massage, exercise, and physical agents including, but not limited to, mechanical devices, heat, cold, air, light, water, electricity, and sound in the aid of diagnosis or treatment**
- **To obtain for physician information needed in diagnosis and evaluation of patients.**
- **To prevent or minimize residual physical and mental disability.**
- **To aid the patient in achieving maximum potential within his capabilities.**
- **To accelerate convalescence and reduce the length of the functional recovery.**

All procedures will be thoroughly explained to you before they will be performed.

There are certain inherent risks with Physical Therapy/Occupational Therapy treatment because you will be asked to exert effort and perform activities with increasing degrees of difficulty, which could cause an increase in your current level of pain or discomfort or an aggravation to your existing injury. There is also a possibility that you could experience a new injury, but this risk is small and you will be able to control any procedure by stopping if you feel any increase in pain or discomfort.

You will also be able to stop treatment if you feel any discomfort in any part of your body. The Physical Therapist/Occupational Therapist and/or Physical/Occupational Therapist's Assistant will take every precaution to ensure that you are protected from any hazardous situation. You will never be forced to perform any procedure that you do not wish to perform.

Based on the above information I agree to cooperate fully and to participate in all Physical Therapy/ Occupation Therapy procedures and to comply with the plan of care as it is established.

Notice to patients: For personal safety, do not use any equipment without a staff member present.

PATIENT NAME _____

DATE: _____ PATIENT SIGNATURE: _____

DATE: _____ LEGAL GUARDIAN: _____

DATE: _____ WITNESS SIGNATURE: _____

3120 E. Union Hills Drive, Suite 202, Phoenix, AZ 85050
Phone: (602) 867-2121 Fax: (602) 867-2424 *AbsolutePT.com*

HIPAA Notice of Privacy Practices

Absolute Physical Therapy Inc. Chad Reilly, PT, MPT
Director of Physical Therapy
3120 E. Union Hills, Suite 202, Phoenix, AZ 85050
Office: (602) 867-2121

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE FOLLOWING CAREFULLY.

USES AND DISCLOSURES FOR HEALTH INFORMATION

Your protected health information may be used and disclosed by your physical therapist, our office staff, and others outside our office that are involved in your care and treatment to provide health care services, pay health care bills, support the operation of your physical therapists' practice, and any other uses required by law.

Treatment: We may use and disclose your health information to a physician or other healthcare provider administering treatment to you.
Payment: Your protected health information will be used, as needed, to obtain payment for health services provided to you.
Healthcare Options: We may use or disclose your protected health information in order to support the business activities of your physical therapists' practice. This includes quality assessment, improvement activities, reviewing the competence qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing services.

We may use or disclose your protected health information with your authorization in the following situations:

- To obtain authorization for physical therapy
- To send requested information regarding you to insurance companies, adjustors, or nurse care managers
- To obtain information regarding benefits and coverage regarding physical therapy.

Other Required Uses and disclosures: Other uses will only be made upon your consent, unless required by law. You may revoke this authorization, in writing, at any time. Your revocation will not affect any use or disclosures permitted by health information for any reason except those described in this notice.

PATIENT RIGHTS

- You have the right to inspect and copy your protected health information provided a written request has been completed and submitted to your physical therapist.
- You have the right to request a restriction of your protected health information for the purposes of treatment, payment, or healthcare options. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care for notification purposes as described in this notice.
- Your request must state the specific restriction requested and to whom the restriction applies.
- Your physical therapist is not required to agree to your restrictions. If the physical therapist believes it is in your best interest to permit use and disclosure of your protected health information, then the information will not be restricted. You then have the right to use another healthcare professional.
- You have the right to request that we communicate with you about your protected health information by alternative means or to alternative location provided a written request has been completed and submitted to your physical therapist.
- You have the right to have your physical therapist amend your protected health information. Under certain circumstances your request may be denied. If your request is denied, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and we will provide you with a copy of any such rebuttal.
- You have the right to receive an accounting of certain disclosures you have made, if any, of your protected health information. You then have the right to object or withdraw as provided in this notice.
- You have the right to file a complaint to us or to the secretary of health and human services if you are concerned that we may have violated your privacy rights, or if you disagree with a decision we have made with access to your health information. You may contact us if any such event occurs. We support your right to the privacy of your health information and we will not retaliate against you in any way if you choose to file a complaint.

Signature acknowledges that you have received and have complied with this Notice of Privacy Practices.

Signature: _____ Print: _____ Date: _____

ABSOLUTE
Physical Therapy Inc.

Cancellation Policy

We are committed to exceptional customer service and clinical care to expedite your healing and recovery process. TO accomplish this, it is extremely important that you attend each of your scheduled appointments. If you know that you will be unable to make a scheduled appointment please call the clinic immediately for rescheduling, and allow us to fill your therapist's time slot. Appointments are in high demand, and your early cancellation will give another patient the possibility to have access to timely medical care.

- We require 24 hours advanced notice of appointment cancellation.
- In the event of late cancellation or "no-show," your account will be assessed a $20 cancellation fee on the FIRST violation. Your insurance will not be billed for this charge; you are responsible for this payment.
- Workers' Compensation patients are not charged for cancellations or no-show, however we are required to notify the patient's Physician, Case Manager, and Employer of non-compliance with therapy. Three cancellations or no-shows during the course of therapy requires your therapist to discharge you from therapy.

Absolute Physical Therapy Inc. appreciates your assistance and understanding with this policy. For questions regarding this policy, please see the front office.
I have read and agree to these terms.

_____ _____
Signature Date

3120 E. Union Hills Drive, Suite 202, Phoenix, AZ 85050
Phone: (602) 867-2121 Fax: (602) 867-2424 *AbsolutePT.com*