BRIAN

KIRK

JENNA

Asheville Physical Therapy™

Orthopedics • Sports Medicine • Sports Performance

Initial Evaluation Appt. Date/Time

Patient Demographic Information

Patient Information -			
Name:		Primary Phone:	
Address 1:		Work Phone:	
Address 2:		Cell Phone:	
City:		Email Address:	
State:		Birth Date:	
Zip Code:		Employer:	

Emergency Contact (if under 18 years old parent or guardian to complete)			
Name:		Home Phone:	
Address:		Cell Phone:	

Referral Information - Written referral Yes / NO *(if no, Must have Primary Physician Name if Medicare)*			
Referring		Primary Care	
Reason for Visit:		Physical or Speech Therapy Elsewhere:	*Yes or No (Yes how many visits_____)*
Date of Surgery:		Surgeon:	
Surgery Notes		Received:	
Case Manager:		Authorization:	Yes or No

Primary Insurance			
Insurance Name:		# of Visits per Year:	
Insurance ID:		# of Visits Used:	
Policy Number:		Effective Date:	
Policy Holder: (Exactly as it appears on card)		End Date:	
Policy Holders DOB:		Relationship to Insured:	*Self / Spouse / Child / Other*

Secondary Insurance	
Insurance Name:	
Insurance ID:	
Policy Number:	

If minor child, must have Guarantor: _____ (printed)

(Must be a parent or legal guardian) _____(signed)

COVID-19 Screening Form

PLEASE ANSWER THE QUESTIONS BELOW, PERTAINING TO YOU AND/OR YOUR HOUSEHOLD.

Yes	No	
		has a fever (>100.4) AND signs/symptoms of acute illness (e.g. cough, difficulty breathing, sudden loss of taste or smell, sore throat, body aches)
		has had close contact with someone with confirmed or suspected COVID-19 within the last 14 days
		has more than one symptom of acute illness (e.g. cough, difficulty breathing, sudden loss of taste or smell, sore throat, body aches)

Patient name:_____

Patient signature:_____

Date:_____ **Reviewed by:**_____

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2023

CONSENT FOR TREATMENT

OPEN AREA EXERCISE: I understand that it may be necessary for me to be treated and/or perform exercise in an open gym area where there may be other patients present. I also understand that if I am not comfortable with this arrangement, I may notify my therapist.

INSURANCE PATIENT:

_____ I understand that it is my responsibility to provide accurate/up to date insurance cards and general information, INCLUDING any address/name change, And **MUST** notify APT **within 7 days** of any changes in insurance.

MEDICARE PATIENT:

_____ I understand that Medicare will cover 80% of their allowed charges per calendar year for services that are medically necessary, and treatment is approved by the physician. The patient or their secondary insurance is responsible for the 20% coinsurance that Medicare does not pay. If there are questions regarding secondary insurance coverage, the patient is to call their insurance company.

_____ I understand Medicare's imposed financial limitations on therapy services and will comply with the financial guidelines. I will contact my insurance carrier (s) if I have specific questions about my policy.

SELF-PAY PATIENT:

_____ I understand that APT **WILL NOT** bill my insurance company. I have chosen a self-pay rate and I am responsible for a flat fee, at the time of services rendered. Asheville Physical Therapy will **NOT** be held responsible to supply the patient with treatment fees or diagnosis codes. I can submit a flat fee to my insurance for reimbursement consideration. A receipt for payment will be offered. (Any other attempt to collect from major medical insurance is considered insurance fraud).

PARENT/LEGAL GUARDIAN OF DEPENDANT PATIENT:

_____ I understand that if my dependent child brings him or herself to an appointment, any deductible, co-pay, co-insurance, or percentage of payment that I am responsible for, is due at time of service. The dependent child/patient must have a credit card on file or a valid form of payment at the time of services are rendered. **If APT is unable to collect payment at the time services are rendered, the staff must reschedule the appointment and late cancellation fee of $49.00 will be charged to card on file.**

DEBIT/CREDIT CARD ON FILE:

_____I UNDERSTAND APT POLICY REQUIRES HAVING THE PATIENT/GUARANTOR'S CREDIT CARD ON FILE. BY INITIALING, I AGREE THAT THE CREDIT CARD ON FILE MAY BE USED WHEN NECESSARY TO PROCESS PAYMENT FOR ANY LATE CANCELATION AND/OR NO-SHOW FEES.

CONSENT TO TREATMENT:

_____I understand that my participation in Physical Therapy is voluntary and by choosing to participate, I am consenting to all rendered services, as deemed medically necessary or appropriate by my therapist. I acknowledge that no guarantees have been made to me regarding treatment and/or the treatment results from APT.

____ (If non-applicable, please insert N/A on the blank line). I agree, with each visit to accompany my underage dependent child/patient. (Under the age of 16). **IF OTHER ARRANGEMENTS NEED TO BE MADE BETWEEN APT AND THE PARENT/GUARDIAN, THEN A WAIVER WILL NEED TO BE SIGNED.**

Printed Name of Patient (18 yrs or older) or Legal Guardian: _____

Signature of Patient (18 yrs or older) or Legal Guardian: _____

Date___/___/___ Reviewed By:_____

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FINANCIAL POLICY AND SIGNATURE ON FILE

I authorize the release of any medical pertinent information to my consulting provider, if needed and as necessary to process insurance claims. I also authorize payment of benefits to Asheville Physical Therapy. I understand that I am financially responsible for all services rendered including for the following reasons:

1. No proper referral at the time of service or referral is invalid/expired.
2. Incorrect/ invalid insurance information given or failure to give any or new updated insurance information.
3. Expenses not covered by insurance including co-pays, co-insurance, durable medical equipment, and maxed insurance benefits.
4. Deductible not met for primary or secondary insurance.
5. Services rendered deemed medically unnecessary by insurance or non-covered/excluded services by plan.
6. Plan is OUT OF NETWORK with Asheville Physical Therapy.

***Failure of an insurance company to pay does not excuse the patient's financial responsibility. It is the patient's responsibility to know what is and is not covered by their insurance policy/plan (Including Medicare beneficiaries). Your contract is between you and your insurance carrier. YOU ARE RESPONSIBLE FOR VERIFYING NETWORK STATUS DIRECTLY WITH YOUR INSURANCE CARRIER.**

PAYMENT AT TIME OF SERVICE AND BALANCES: Payment is required for all services at the time they are rendered including co-payments, co-insurance, deductibles, and any outstanding balances. Outstanding balances will have credit card/debit card transacted at the time insurance payment is processed. Any unpaid balances greater than 30 days old will result in an 18% interest penalty unless arrangements have otherwise been approved by management. (I understand the liability action against someone is not a reason for delaying payment of my bill. Payment is my responsibility as an individual receiving treatment).

Returned Checks: In the event a check is returned for Non-Sufficient Funds, we will assess a **$25.00** charge in addition to your current balance to cover bank charges incurred by our office due to Non-Sufficient Funds.

Missed Appointments: We charge a **$49.00** fee for any **NO SHOW** appointment and/or **LATE CANCELLATION** that **WAS NOT CANCELED** WITHIN **24** HOURS. This will be processed using your credit card/debit card on file, or will be billed directly to you. If you "NO SHOW" to 3 appointments within a year we have the right to dismiss you from our practice for non-compliance.

Late to Appointment: I understand that if I am going to be late for an appointment. APT expects a courtesy call from the patient/patient guarantor. My time slot may likely be forfeited if I am more than **15** minutes late. (I will make every reasonable attempt to notify APT if I am running late for any reason).

Your signature below signifies your understanding and willingness to comply with the policies of this office and your insurance plan.

Patient/Guardian Signature for Financial and Office Policies
(Refusal to sign does NOT prevent responsibility/obligation regarding this office's financial policy).

X_____ **Date**_____

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PATIENT HIPAA NOTIFICATION POLICY AND CONSENT

At Asheville Physical Therapy, we are committed to protecting your privacy. We comply with all federal, state, and local laws. This notice describes how we use your health information. It describes some of your rights and responsibilities.

UNDERSTANDING YOUR HEALTH RECORD/INFORMATION: Each time you visit our office, we record your symptoms, physical abilities, test results provided, diagnosis, and treatment. This information enables us to plan for your care, communicate with others who care for you, report to your insurance carrier, bill for our work and improve the quality of our care for you.

YOUR RIGHTS: Although your medical chart belongs to our practice, the information contained in the chart is yours. You have the right to inspect your records, obtain a copy of your chart for a small fee, correct your records, and tell us not to release your information to certain parties (Notebook in front waiting room).

OUR RESPONSIBILITIES: We are required to maintain the privacy of your health information, send needed health information to other medical providers, and release information to insurance companies, certain government agencies, and others. We may be required to release some information, even without your permission.

EXAMPLES OF HOW YOUR INFORMATION IS USED: Your health information will be recorded and used to plan your treatment. Reports may be sent to other doctors to help them plan your treatment. Claims will be sent to your insurance company. The information in the claims will include confidential information such as your name, address, diagnosis, and treatment. In providing your care, we may communicate with other individuals or businesses.

OTHER NOTICES: We may leave a message on your cell phone, at your home or your business. We will communicate with you regarding your medical information by phone, email or written letter only. Please do not text our staff to discuss your medical information. We may use phone, email or text to remind you of your upcoming appointments. We may email you or mail you written notices. We may disclose your health information to your family members or other people helping with your care, UNLESS you direct otherwise, by notating below. In doing so, we will use our best judgment. We may disclose information to others as required by law or by subpoena. If you were injured on the job, we will need to disclose your health information to your workers compensation insurance company. Asheville Physical Therapy reserves the right to update policies as needed.

COMPLIANCE: We comply with HIPAA regarding your Personal Health Information (PHI).

FOR INFORMATION, QUESTIONS, OR TO REPORT A PROBLEM: You may contact our Office Manager/Co-Owner, Kelly Lawler

HIPPA CONSENT: Without signed consent, we CANNOT share your information regarding your medical care (including family). Please list below, anyone you wish to have information regarding your care.

1._____ 2._____

☐ **I do NOT wish anyone to have information regarding my care.**

Patient/Responsible Party signature (HIPPA Policy)

Name:_____ Date:_____

Reviewed by:_____

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(WE DO NOT TAKE AMERICAN EXPRESS)

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PATIENT NAME:_____

CREDIT CARD HOLDER NAME: _____

CREDIT CARD #: _____

EXPIRATION: _____ **CVC CODE#:**_____

ZIP CODE ASSOCIATED WITH CARD: _____

☐ **NOTED "CC ON FILE" ON ACCOUNT AND IN SCHEDULE**