Callan-Harris Physical Therapy, PC

PLEASE READ CAREFULLY & INITIAL

Consent for Care & Treatment

_____ I do hereby consent to rehabilitation & related services at Callan-Harris Physical Therapy, PC (hereafter "**CHPT**"). In doing so, I understand that there are no guarantees as to the result of the treatment(s) I may receive. I have been given the opportunity to ask questions & my questions have been answered to my satisfaction.

Assignment of Insurance Medical Benefits | Insurance Verification Disclaimer | Financial Responsibility

_____ I assign all insurance medical benefits, to which I am entitled, to CHPT & request that payment of benefits be made on my behalf to CHPT for any services provided to me. I authorize & instruct my insurance company to pay by EFT or by check & by mail directly to:
Callan-Harris Physical Therapy, PC, 1328 University Ave, Rochester, NY 14607

CHPT will obtain a quote of benefits as a courtesy to our patients & we are, at no time, to be held responsible for incorrect information that has been provided by your insurance company. We provide you with a summary of your benefits & not a guarantee of payment. Eligibility & benefits will be determined at the time your claims are processed. The deductible & copayment due is an approximation of the amount you are responsible for based on your insurance coverage.

_____ **Full payment for any balance due**, **including copayments, is expected at the time of service unless other arrangements are made prior to the scheduled visit. $65 payment** is due at time of visit for patients with a **High deductible plan** (have not yet met) & will be credited to your account. Payment may be made by cash, credit or check. I understand that a fee of $25 will apply to any bounced/returned check.

_____ I, the patient, am to keep all payments current and account up to date. There will be a **$5 fee** for any balance that is past due by 30 days and have not already set up payment plan agreement. Should my account go to collections, I agree to pay all attorney's fees, court costs, filing fees, and all other charges that may be assessed.

_____ **Visits per Calendar/Plan Year.** Many plans have a **Max # of visits** allowed for calendar for physical therapy (PT), occupational therapy (OT) & speech therapy, combined. If you exceed max amount, you will be responsible for charges for services.
Have you had any PT, OT and/or speech therapy at another facility this calendar/plan year? YES _____ NO_____
If yes, how many visits have you had? _____ visits

_____ **Insurance Changes/Updates.** I will notify CHPT of any changes or updates with regards to my insurance or billing information by the date of any change/update. I will be responsible for any treatment dates that are not covered if I fail to do this in a timely manner.

_____ **I shall be financially responsible for any & all charges that are not covered by my insurance company.**

Late Cancellation & No-Show Policy

_____ I understand that a specific time slot is reserved for me when I schedule an appointment, & I accept full responsibility for my scheduled appointments. **I will notify the front desk of any and all scheduling changes, my therapist is not responsible for my scheduled appointments.**

_____ If I am unable to keep my scheduled appointment, I will provide CHPT **at least 24 hours notice** so that CHPT may reschedule my appointment & offer that time slot to another patient in need of physical therapy services.

_____ **$ 40 fee for any Late Cancelation** (less than 24 hours notice) I understand that this fee is not covered by insurance & that I will be personally responsible for any Late Cancellation fees**. I understand that I will need to pay this fee prior to my next visit.**

_____ **$ 50 fee for any No Show** if you do not call to cancel your appointment prior to your appointment and do not show up. I understand that this fee is not covered by insurance & that I will be personally responsible for any No Show fees**. I understand that I will need to pay this fee prior to my next visit.**

This policy is designed to open otherwise unused appointments for our patients that need to be seen, not to collect late and missed appointment fees. Your cooperation and consideration are greatly appreciated!

PLEASE READ CAREFULLY & INITIAL

Is your injury a result of a motor vehicle accident or work-related injury?

_____ **Yes** - You must notify the Front Desk if your reason for treatment is due to an auto accident or hurt on the job, if you haven't already. There are additional forms that will need to be completed. Your health insurance will not cover your treatment and deny payment for services. You will be responsible for all outstanding balances.

If yes, please check which one:

Work-related Injury/Worker's Compensation Case _____ **Motor vehicle accident/No-Fault Case** _____

_____ **No**

N/A _____ **Medicare – ONLY**

Medicare limits coverage for rehabilitation services to a certain dollar amount per calendar year. This includes physical therapy (PT), occupational therapy (OT), speech therapy & chiropractic treatment, combined. Therefore, it is critical that you provide us an accurate number of visits you have made to other providers for these services in this calendar year, & whether or not they are still on-going. This will allow us to verify the number of visits that Medicare will allow for PT at CHPT. Medicare does not cover for PT provided by CHPT where the patient is also receiving any Home Health Care services. Accordingly, please answer the following:

_____ The information I have provided for my Insurance Information is accurate & complete.

_____ **I currently am NOT receiving any Home Health Care services of any kind**, this includes any of the following services: nursing services, OT, PT, speech therapy, home health aide services and medical social services from a Home Health Agency. If I have had Home Healthcare Care with in the last 3 months, I will provide my letter of discharge from all my home care services. If I am referred for Home Healthcare Care services while being treating by CHPT, I will inform the office prior to starting home health care. I am aware that I will be responsible for any payment of services that is not covered due to failure to disclose my Home Health Care services prior to being seen.

_____ I will keep CHPT informed of any additional rehabilitation service visits I have at another outpatient physical therapy clinic.

Have you had physical therapy this year? YES _____ NO_____

If yes, How many visits have you had this year? _____ visits

_____ I will be financially responsible to CHPT for any visits that are not covered by Medicare to the extent that I did not inform CHPT, in writing, of outside rehabilitation service visits.

N/A _____ New York State Medicaid / UnitedHealthcare Community Plan / UnitedHealthcare Dual Complete plan - ONLY

Currently we do NOT accept New York State Medicaid, UnitedHealthcare Community Plan (UHC Medicaid) & the Medicaid portion of the UnitedHealthcare Dual Complete Plan.

_____ **NY STATE Medicaid / UnitedHealthcare Community plan (UHC Medicaid).** I am aware that CHPT does not accept NY STATE Medicaid or the UnitedHealthcare Community plan. I understand and agree I will have to pay as a **Self Pay** patient for my physical therapy at CHPT. I understand that payment is due at the time of treatment.

_____ **NY STATE Medicaid as your secondary insurance.** I am aware that CHPT does not accept NY STATE Medicaid. I understand and agree I will have to pay the **20% Coinsurance** portion that is due, that would normally be paid by NY STATE Medicaid, for my physical therapy at CHPT.

_____ **UnitedHealthcare Dual Complete Plan**. I am aware that CHPT does not accept the Medicaid portion of the Dual Complete plan. I understand and agree I will have to pay the **20% Coinsurance** portion that is due, that would normally be paid by the Medicaid portion of my insurance, for my physical therapy at CHPT.

N/A _____ **Consent for Treatment of a Minor**

_____ As parent and/or legal guardian, I authorize CHPT to treat the minor patient named below while I am not present.

***** I have read the Office/Financial Policies in its entirety and agree to the Terms and Conditions.*****

Patient Name (print): _____ **DOB:** _____ /_____ /_____

Patient Signature: _____ **Date:** _____

Minor Only Parent/Legal Guardian Name (print): _____

Parent/Legal Guardian Signature: _____ Date: _____

Patient Medical Information

Patient Name: _____ **Age:** _____**Today's Date:** _____ /_____ /_____

What is your reason for coming to Physical Therapy today? _____

_____

What are your goals and expectations for physical therapy? _____

_____

Current Injury, Surgery, or Pain

Height: _____ **Weight:** _____

Date of Injury: _____ **Date of Surgery:** _____ **Date Pain Started:** _____

Referring Physician: _____ **Last MD Visit:** _____ **Next MD Visit:** _____

Is your injury related to any of the following?

☐ Work ☐ Car accident ☐ Surgery ☐ Lifting/Carrying ☐ Fall

☐ Slow onset ☐ Athletics ☐ Chronic/Reoccurring

Occupation: _____ Work Status: ☐FT ☐PT ☐Unemployed

Diagnostics performed for this condition?

If yes, date: _____ ☐X-ray ☐MRI ☐CT Scan ☐EEG ☐EMG ☐Injections

Have you received treatment for your condition before today?

If yes, from whom: _____

☐ Medical Doctor ☐ Chiropractor ☐ Physical Therapist ☐ Other: _____

Have you recently experienced any of the following:

☐ Dizziness/Lightheaded ☐ Difficulty swallowing ☐ Muscle weakness

☐ Fainting ☐ Changes in bowel or bladder ☐ Numbness/Tingling

☐ Unexplained weight loss ☐ Incontinence ☐ Are you pregnant, # wks _____

Allergies

Please list any allergies:

Medical History

Have you ever been diagnosed with any of the following?

- ☐ High / Low blood pressure
- ☐ Heart problems
- ☐ Stroke / CVA
- ☐ Pacemaker
- ☐ Blood clots / Circulation issues
- ☐ Diabetes: Type 1 / Type 2
- ☐ Osteoporosis
- ☐ Arthritis: OA / RA
- ☐ Cancer: _____
- ☐ Bladder / Urinary / Kidney Disease
- ☐ Lung Problems COPD / Emphysema
- ☐ Tobacco / Marijuana / Vape # _____ / day
- ☐ Asthma
- ☐ Seizures
- ☐ Neurological disease: MS / Parkinson's
- ☐ Depression / Anxiety / Panic
- ☐ Neurodevelopmental Disorders: ADHD / ADD / ASD Dystonia / Tourette's
- ☐ Back pain: Degenerative / Stenosis / Herniation
- ☐ Back injury
- ☐ Neck injury
- ☐ Chronic headaches
- ☐ Other injury: _____
- ☐ Fracture: _____
- ☐ TB / HIV / Hepatitis A, B, C
- ☐ Visual / Hearing Impaired
- ☐ Thyroid: Type: _____

Other Issues not listed: _____

_____

_____

Surgical History

Joint Replacement(s)	please explain: _____	date: _____
Orthopedic Surgery	please explain: _____	date: _____
Heart Surgery	please explain: _____	date: _____
Fracture Repair	please explain: _____	date: _____
Spinal Surgery	please explain: _____	date: _____
Other Surgeries	please explain: _____	date: _____

Current medications: ☐ See attached list

Medication Name	Dosage	Frequency

I understand that it is important for my therapist to understand my medical history in order to create a comprehensive treatment plan. I certify to the best of my ability; the above information is complete and accurate.

Patient / Guardian Signature _____ **Date** _____

Patient Name _____ **DOB** _____ /_____ / _____

Patient Information ☐Minor

Name: Last _____ **First** _____ **Preferred** _____ **MI** _____

DOB: _____/_____/_____ Age _____ | **Marital Status:** ☐Married ☐Single ☐Other | **Student:** ☐**Yes**: FT / PT ☐**No**

Gender: ☐M ☐F | *(Optional)* **Gender Identity**: ☐M ☐F Other _____ Pronouns _____

Address _____ **City, State, Zip** _____

Phone Numbers: Cell _____ **Home** _____ **Work** _____

Are we able to leave a detailed voicemail? ☐**Yes** ☐**No** | Preferred Phone: ☐Cell ☐Home ☐Work

Email _____ **Would you like appointment reminders by email?** ☐**Yes** ☐**No**

Billing Information

Please Select: ☐Private Insurance ☐Medicare ☐Medicaid ☐Self-Pay ☐Worker's Compensation ☐No-Fault

Responsible Party: Last _____ First _____ MI _____

Phone Numbers: Home _____ Work _____ Mobile _____

DOB _____/_____/_____ Relationship to Patient _____

Address: _____ City, State, Zip _____

Is this Worker's Comp or an auto accident? ☐YES ☐NO Date of injury/accident _____/_____/_____

Insurance Company _____ Case # _____

Case Manager Name _____ Phone _____ Fax _____

Employer _____ **SS#** _____ **(needed to receive payment)**

Employer Address _____ City, State, Zip _____

Insurance Information

Primary Insurance _____

Subscriber Name _____

Subscriber: Date of Birth _____/_____/_____

Relationship to Patient _____

Insured Policy ID # _____

Group Number _____

Effective Dates _____

Secondary Insurance _____

Subscriber Name _____

Subscriber: Date of Birth _____/_____/_____

Relationship to Patient _____

Insured Policy ID # _____

Group Number _____

Effective Dates _____

Emergency Contact

Name: Last _____ First_____ Relationship to Patient _____

Address _____ City, State, Zip _____

Phone Numbers: Cell_____ Home_____ Work _____

Release of Information

I authorize Callan-Harris Physical Therapy to provide my confidential health information to the following individuals:

Name: Last _____ First _____ Relationship to Patient _____

Name: Last _____ First _____ Relationship to Patient _____

Name: Last _____ First _____ Relationship to Patient _____

Authorizations & Acknowledgements

☐ I hereby certify that the above information is complete and accurate according to the best of my knowledge and ability.

☐ I understand that the information provided above may be used and shared for the purposes of treatment, billing for services rendered, and conducting of administrative operations of Callan-Harris Physical Therapy per their **Notice of Privacy Practices** which I have had an opportunity to read, review, and receive. (They are available at the reception desk when requested)

☐ I give my consent to proceed with a therapy evaluation and corresponding treatment. I also give my consent that services may be observed and/or provided by a PT or PTA student under the supervision and instruction of a licensed physical therapist. Due to the nature of physical therapy and the physical exertion required to perform activities with increasing degrees of difficulty, I understand that there may be possible complications associated with my care such as an increase in my current level of pain, an aggravation of my existing injury, or very rarely, the development of a new injury. My signature below acts as a waiver of liability for treatment received at Callan-Harris Physical Therapy excepting acts of negligence.

Patient/Guardian Signature: _____ Date: _____

Patient Name (Print): _____ DOB: _____ /_____ /_____