Kellogg Physical Therapy, Inc

Consent for Treatment, Billing Agreement and Privacy Policies

Information for patients without insurance:
If you do not have insurance coverage, you will be expected to pay for your bill, in full at the time of service, or make appropriate payment arrangements with one of our administrative staff members. For your convenience we accept cash, checks, Care Credit, major credit cards and debit cards.

Information for patients with insurance:
Insurance coverage is a contract between you, your insurance company, and in many instances your employer. As a courtesy to you, we will file your medical claim with your insurance company in a timely manner. In most instances, we will accept payment directly from your insurance company in accordance with your policy's terms and apply the payment to your account. Contractual discounts will be applied at that time.

You are responsible for any co-payment, co-insurance, or deductible. Co-pays are expected at the time of service. Even though we provide you with the most up to date information about your benefits, ultimately, you are expected to know your co-pay and deductible amounts. We accept payment plans only through Care Credit. Please ask the office staff for an application or visit www.carecredit.com.

You will receive periodic statements indicating that we have billed your insurance company on your behalf. However, **you are ultimately responsible for payment of your physical therapy services.**
If your insurance company fails to pay your claim in a timely manner, or rejects your claim in part or in full, you are personally responsible for, and will be billed directly for the services you received. If that happens you may want to contact your insurance company directly or your insurance plan administrator at your place of employment to discuss the reason for the denial of benefits.

MISSED APPOINTMENT POLICY:

Our commitment to your well being is something everyone in our clinic takes very seriously. Because we care so much about you, we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need. Therefore, we expect you to keep all of your appointments. However, cancellation or the rescheduling of an appointment must be requested within 24 hours notice of scheduled appointment time or a $25.00 cancellation / no-show fee will be assessed.

HIPPA/PRIVACY POLICY:

We are required by law to maintain the privacy of your health information and provide you with a copy of our Privacy Policy. Specifically HIPPA and KPT's Privacy Policy individually identify you and relate to
(1) your past, present, or future physical or mental health; (2) related health care services; or (3) your past, present or future payment for your health care. Under no circumstances is your private health care information given to anyone unless your consent is given. If you wish for someone to be authorized to assist you with your care at KPT, written consent will be needed. We may use health information about you to provide, coordinate or manage your health care and related services. We may disclose health information about you to your doctor, staff or others who are involved in taking care of you and your health. For example, your doctor may be treating you for a heart condition, which we may need to know about to determine the best plan of care. If you have any further questions about our HIPPA or Privacy Policy we have a copy at the front desk.

- **I have read and agree to the terms of this statement.**
- **I consent to receive Physical Therapy care at Kellogg Physical Therapy.**

_____	_____	_____	_____
Signature of Patient or Guardian	**Date**	**Printed Name of Patient**	**Date of Birth**

Kellogg Physical Therapy, Inc

PATIENT INFORMATION:

Name _____ **DOB:** _____

Last **First** **MI**

Sex: Male Female Marital Status: Single Married Widow Email: _____

Mailing Address _____City _____State ___ Zip _____

Physical Address (if different) _____

Cell Phone_____ Home Phone _____

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Preferred method for appointment reminders: **circle one**

Text **Phone Call** **Email**

How did you hear about Kellogg PT? Physician Phone Book Internet Friend Other

Responsible Party (if different from patient):

Parent / Guardian Name:_____ Relationship: _____

Address:_____ Phone: _____

PHYSICIAN INFORMATION:

Referring Physician_____ Primary Physician _____

ACCIDENT INFORMATION: Type: Work Auto Sport Other

Date of Injury:_____ Claim #:_____ Place of Injury: _____

Brief Description of Injury: _____

_____

INSURANCE INFORMATION:

(If you have your insurance card so we can copy it, then you do not need to fill this part out.)

Primary Ins:_____ Subscriber Name: _____

Date of Birth:_____ Policy #:_____ Group #: _____

Secondary Ins._____ Subscriber Name:_____

Date of Birth:_____ Policy #:_____ Group #: _____

_____**No Insurance: Pay at time of service unless prior arrangements made.**

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MEDICAL PROFILE QUESTIONNAIRE

Patient's Name: _____ DOB: _____ Date: _____

Height_____ Weight _____

What are your main complaints or concerns (what brought you to therapy)?

_____

_____

What is your main goal or objective in coming to therapy?

_____

_____

I f any, what other treatment has been tried for this problem (medications, chiropractic, ice…)**?**

_____

Have you fallen within the last year? Yes No

If yes, how many times? _____ Were you injured in the fall(s)? Yes No

Have you ever been diagnosed with:

Depression? Yes No Bi-polar Disorder ? Yes No

Medications* (Prescription and Over the Counter) or supplements you are currently taking

Name	Dosage	Frequency (circle one):	Form (circle one):
		times a day / week	Oral Injection Other:
		times a day / week	Oral Injection Other:
		times a day / week	Oral Injection Other:
		times a day / week	Oral Injection Other:
		times a day / week	Oral Injection Other:
		times a day / week	Oral Injection Other:
		times a day / week	Oral Injection Other:
		times a day / week	Oral Injection Other:
		times a day / week	Oral Injection Other:
		times a day / week	Oral Injection Other:
		times a day / week	Oral Injection Other:

*Please attach a separate list or use the back of this page if you need more room for medication list.

On a scale from ZERO (0) as NO PAIN, and TEN (10) as THE WORST PAIN, rate:

The best it has been_____/10. The worst it has been_____/10. Pain in the past week_/10.

Pain at rest_____/10. Pain with activity_____/10. Pain now_____/10.