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 24 hours notice or no-show to a scheduled appointment, a $25.00 cancellation 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 Pinnacle's Privacy Policy individually identify you and relate to (1) your past, present, or future physical or mental health; (2) related healthcare services; or (3) your past, present or future payment for your healthcare. Under no circumstances is your private healthcare 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 healthcare 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/Guardian   Date   Printed Name of Patient   Date

Kellogg Physical Therapy, Inc

PATIENT INFORMATION:

Name ____ DOB: ____________

Last First MI

Sex: Male Female Marital Status: Single Married/Partner Email:______________________

Mailing Address__________________________City_______________State ______Zip_____________

Physical Address (if different from current address) ____

Home Phone_____________________________Cell Phone ___________________________________

Emergency Contact: ____ Phone: __________________

Employer: _______________________________Occupation: ___________________________________

Preferred method for appointment reminders: Text Phone Call

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

Responsible Party (if different from patient):

Parent / Guardian Name:____________________________________

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 we can copy and 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

Name____ **Age** __________ **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?

____

____

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

____

MEDICARE PATIENTS: Have you fallen within the last year? Yes No

If yes, how many times?______ **Were you injured in the fall(s)?**______________________________

Past Medical History: Please mark any you *have* or *have had*

☐	Cancer(s):	☐	Diabetes
☐	Surgeries:	☐	Head Injury
☐	Heart problems:	☐	Seizures
☐	Do you have a pacemaker / defibrillator? Yes No	☐	Stroke
☐	Arthritis:	☐	Lung Problems
☐	Tape or latex allergies Yes No Any other	☐	High Blood Pressure
☐	Vascular problems:	☐	Depression
☐	Hospitalizations:	☐	Thyroid Problems
☐	Other:	☐	Kidney Problems

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:

*If medication outnumbers four, please attach a separate list or use the back of this page.

Patient's Name: **Date:______________**

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.

When did your symptoms begin? (as close to the actual date as possible) _____________________________________

How would you rate your overall health (circle one): Excellent Good Fair Poor Very Poor

Shade the location of pain in the body diagram and circle your pain descriptions below:

Aching *Dull*

Stabbing *Radiating*

Shooting *Catching*

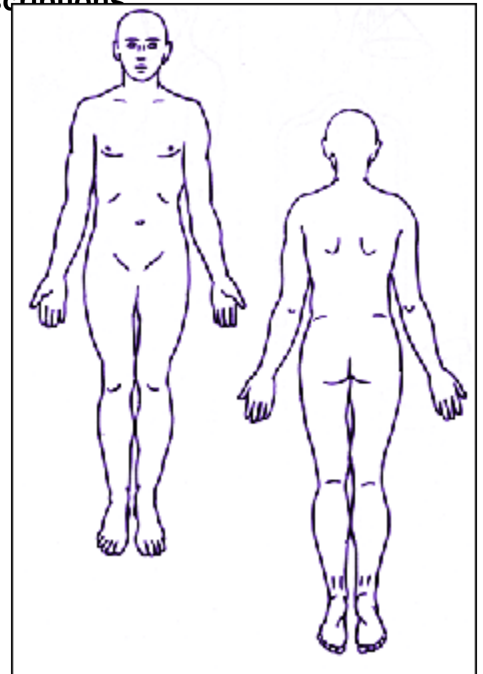
Throbbing *Burning*

Numbness *Tingling*

Pins & Needles *Sharp*

Pain Key:

== Numbness
XX Burning
++ Aching
/// Shooting
Pins/Needles



Have you had this problem before? YES / NO If YES, did you receive treatment and was it helpful?

____

Before the present pain / injury, what types of exercise / activities were you doing, how frequent?

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