



NEW PATIENT PAPERWORK

PATIENT INFORMATION

_____ **SS#:** _____

First Name _____ **Initial** _____ **Last Name** _____

Date of Birth: ____/____/____ **Age:** _____ **Gender:** Male Female **Email:** _____

Phone Numbers: (Home) _____ **(Cell)** _____

Home Address (including city, state, and zip code):

Street: _____ **APT #:** _____ **City:** _____ **State:** _____ **Zip:** _____

Emergency Contact: _____ **Phone:** _____ **Relation:** _____

HOW DID YOU HEAR ABOUT US?

- | | |
|---|--|
| <input type="checkbox"/> Doctor Referral | <input type="checkbox"/> Social Media |
| <input type="checkbox"/> Returning Patient | <input type="checkbox"/> Summit/Thrive Event |
| <input type="checkbox"/> Sports Barn | <input type="checkbox"/> Insurance |
| <input type="checkbox"/> Internet Search | <input type="checkbox"/> Saw our sign |
| <input type="checkbox"/> Friend/Family: _____ | <input type="checkbox"/> Other: _____ |

INSURANCE INFORMATION

(If this is a work-related injury you may skip this section.)

Carrier: _____ **Policy #:** _____ **Group #:** _____

Policy Holder (if other than self): _____ **Date of Birth:** ____/____/____

Relationship to Patient: Spouse Parent/Guardian Other: _____

HAVE YOU ATTENDED: physical therapy, occupational therapy, speech therapy, or seen a chiropractor this calendar year? Yes No

Do you have any other medical insurance not listed above? Yes No If yes, please fill out information below.

Carrier: _____ **Policy #:** _____ **Group #:** _____

Policy Holder (if other than self): _____ **Date of Birth:** ____/____/____

Relationship to Patient: Spouse Parent/Guardian Other: _____

PHOTOGRAPHIC IMAGE/VIDEO RELEASE

May Summit/Thrive Physical Therapy utilize photographic images, video recording or written information of you or your child (if patient is a minor), for the purposes of community education, outreach, or marketing of SPT/TPT programs and/or services?

- Yes
- No

CONSENT TO TREAT

By signing below, I consent to treatment by Summit/Thrive Physical Therapy and their therapists and acknowledge that it is my responsibility to provide SPT/TPT with correct billing information. Treatments could include but are not limited to hands on/manual mobilization, exercise, thermal and non-thermal modalities, dry-needling, and laser therapy. Some treatments may not be billable to my insurance and are cash services.

**All patients under the age of 18 must have a parent/guardian present for their first appointment.*

Signature: _____ **Date:** _____



WORKER'S COMPENSATION/MVA

1. Were you injured at work and pre-approved by your employer under Worker's Compensation Insurance?

Yes

Injury/accident occurred on: _____ / _____ / _____

In what state did your injury occur? _____

Employer Name: _____

Employer Address: _____

Employer Phone: _____

Position/Title: _____

No

2. Were you injured in a Motor Vehicle Accident (MVA)?

Yes

Injury/accident occurred on: _____ / _____ / _____

In what state did your accident occur? _____

- If you have an attorney, please list attorney, law firm, and phone number below:

Attorney: _____ Law Firm: _____

Phone: _____

No

Disclaimer: If you have been in a motor vehicle accident and wish to bill your health insurance for services provided, please know that many times we see insurance: deny the claim(s) due to another party being liable, or insurance may pay initially, only to take back payment when discovering another party should be financially responsible.

**** Please be advised that any denial from your insurance, or any recoupment of payment by your insurance, will be rolled over to patient responsibility. You will be financially responsible for all services rendered if your insurance denies services. ****



SUMMARY OF NOTICE OF PRIVACY PRACTICES

Effective June 30, 2008

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review the full Notice of Privacy Practice (NPP) which is below. If you have any questions about this notice, please ask your Physical Therapist.

We understand that health information about you and your healthcare is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by this practice, whether made by your personal doctor or others working in the office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to health information we keep about you and certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

1. Make sure health information that identifies you is kept confidential
2. Give you this notice of our legal duties and privacy practices with respect to health information about you
3. Follow the terms of the notice that is currently in effect

The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our practice. There are also various other ways in which we may use or disclose your information. Examples: appointment reminders, to allow oversight of the quality of the healthcare we provide as required by subpoena in lawsuits and disputes, various uses as required by law or to avert a serious threat to health or safety.

You have the following rights regarding health information we maintain about you:

1. Right to inspect and copy
2. Right to amend
3. Right to an accounting of disclosures
4. Right to request restrictions
5. Right to request confidential communications
6. Right to paper copy of this notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will furnish you a copy of the current notice if requested. The notice on this page will contain an effective date. In addition, each time you register for treatment or healthcare services, you are welcome to a copy of the current notice in effect. If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact your Physical Therapist. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you for the reasons covered by our written authorizations. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provide to you.

Designated Representatives

The following people may call and receive medical information on my behalf.

Name

Relationship

I acknowledge that I have read and received the Privacy Policy on: _____/_____/_____.
(Today's Date)

Signature of Patient/Responsible Party: _____

Relationship to Patient: Self Parent/Guardian Other: _____



MEDICAL HISTORY QUESTIONNAIRE

Patient: _____ Age: _____

Height: _____ Weight: _____ Occupation: _____

1. What are your symptoms? _____

2. When did your symptoms start? _____

3. Are your symptoms the result of an injury? Yes No

If yes, briefly describe: _____

4. Have you had surgery in the past year? Yes No If yes, surgery date: ____/____/____

5. Are your symptoms Constant Intermittent

6. Are you experiencing pain? Yes No If yes, is your pain: Sharp Dull Achy Deep Burning Throbbing

a. From 0-10, what is your pain level at rest: _____ During Activities: _____

(0 being no pain, 10 being unbearable pain)

7. What activities make your symptoms/pain worse? _____

8. What can you do to relieve your symptoms/pain? _____

9. Does your condition affect your sleep? Yes No If yes, can you go back to sleep? Yes No

10. How do you feel in the morning? Worse Better Stiff Sore Fine

11. Have you had any tests since this problem started? X-Ray MRI CT Scan EMG

12. Have you ever had anything similar to this condition? _____

13. Do you exercise? Yes No If yes, please describe: _____

14. In the last three months, have you had any of these symptoms (check all that apply):

Fever

Dizziness

Weight Loss

Night Sweats

Vomiting

Abdominal Pain

Fatigue

Shortness of Breath

Fainting

Diarrhea

Leg Cramps

Sweating

Nausea

Headaches

15. Do you have symptoms before, during, or after eating? Yes No

16. Are you pregnant? Yes No

17. Have you had joint replacement? Yes No

18. Have you been treated for cancer? Yes No

19. Do you have chest pain? Yes No

20. Please list all medications you are currently taking or provide the front desk with a copy of your medication list. _____



Financial Agreement

Thank you for choosing Summit/Thrive PT for your Physical Therapy needs. This financial agreement describes both patient and insurance responsibilities for services rendered. Please read this agreement and sign the space provided.

INSURANCE

Medical Insurance coverage is a contract between you and your insurance company. We ARE NOT a party to this contract. It is your responsibility to know your insurance benefits including referrals, pre-certifications and required authorizations. As a courtesy to you, Summit/Thrive PT will file claims to your medical insurance company(s) for the services that are provided by our office. If we are given incorrect or incomplete information, you will be billed in full. In order for the claims to be processed correctly, please ensure that the information provided to our office is accurate and current. This may require you to call your insurance company(s) and update your COB (*Coordination of Benefits*). **If there is a change in your insurance information, please notify us immediately.**

We will not be involved in disputes between you and your insurance company(s) regarding deductibles, copayments, coinsurance, covered charges, secondary insurance, usual and customary charges, etc., other than to supply factual information as necessary. **You are responsible for the timely payment of your account, and any outstanding balances or uncovered services.**

PATIENT RESPONSIBILITY & PAYMENT

Payment of copays, coinsurance, and deductibles will be due at the time of service. Our failure to collect these amounts may be a violation of our contract with your insurance company. You are responsible if your insurance denies a claim for any reason.

Copayments: are constant and due at the time your services are rendered.

Coinsurance and deductible payments: vary for each insurance policy, and we can only approximate what your financial responsibility will be.

- We will collect a percentage of what we estimate will be due at the time of service, based on your coverage percentage and collect that amount at the time your services are rendered.
- You will receive a statement or be verbally notified by the front desk when your claims process and we see what balance remains.

PAYMENT OPTIONS

We accept cash, check, and all major debit/credit cards: Visa, Mastercard, Discover, American Express. *Please note that we do not keep cash on hand, and we may not be able to provide change if you do not provide exact payment.*

We understand that financial circumstances vary from patient to patient. If you are unable to pay your due balance in full, please discuss options with the front desk or you may reach our Billing Department at 423-661-3250 to make payment arrangements.

PAYMENT PROCESSING

To ensure timely and efficient payment processing, we will securely store your credit/debit card information in our system. Your card will be charged automatically for any applicable copays, coinsurance, and deductible amounts as they are due.

Upon discharge, if a balance remains after final claims processing, you will be notified of the remaining amount, and your card on file will be charged for the balance.

All card information is stored securely in compliance with PCI-DSS standards.

I have received this financial agreement and understand that regardless of any insurance coverage I have, I am responsible for payment of my account.

Patient Signature

Printed Name

Date



PATIENT CANCELLATION & MISSED APPOINTMENT POLICY

At Summit/Thrive Physical Therapy, we understand that unexpected situations can arise, and there may be times when you need to cancel or reschedule your appointment. We will always do our best to work with you during those times. However, we kindly ask that you provide as much notice as possible when canceling an appointment.

Providing adequate notice allows us the opportunity to offer that time slot to another patient who is waiting for care. Your scheduled appointments are an important part of your treatment plan, and consistent attendance plays a vital role in your progress and recovery.

Policy Details:

- If you must cancel, we ask that you notify us as soon as possible and ideally reschedule your appointment within the same week.
- If you cancel without rescheduling in the same week or do not show up for your scheduled visit, a \$25.00 missed appointment fee may be applied.
- Repeated missed appointments or late cancellations without adequate notice may result in discontinuation of care. If this occurs, we will notify your referring provider that therapy services have been discontinued due to non-compliance with the prescribed rehabilitation plan.

We appreciate your understanding and your commitment to your recovery. Thank you for choosing us to support you in your wellness journey!

I have read and fully understand the Cancellation & Missed Appointment Policy outlined above. I acknowledge that I am responsible for attending my scheduled appointments or providing adequate notice if I need to cancel. I understand that failure to do so may result in a missed appointment fee or possible discontinuation of care.

Patient Signature: _____ **Date:** _____