
## PATIENT INFORMATION

Today's Date: _____

Name: _____

☐Male ☐Female Date of Birth: _____/_____/_____ Marital Status: ☐Single ☐Married

Address: _____
Street Address City State Zip Code

Email Address: _____

Would you like to receive appointment reminders by email? ☐ Yes, Notify me by email.
☐ No, Do not email me.

Home Phone: (_____) _____-_____ ☐Cell Phone: (_____) _____-_____

Would you like to receive appointment reminders via text message? ☐ Yes, Notify me by text.
☐ No, Do not text me.

Employer: _____ Occupation: _____
(REQUIRED FOR WORKER COMPENSATION CASES)

Emergency Contact: _____

Phone: (_____) _____-_____ Relationship to patient: _____

**REFERRING DOCTOR:**

Name: _____

Phone: (_____) _____-_____

**PRIMARY CARE DOCTOR (PCP):**

Name: _____

Phone: (_____) _____-_____

## CONSENT FOR TREATMENT

I hereby consent to and authorize all therapy treatments, which in conjunction with the judgment of my attending physician, may be considered necessary and/or advisable for the diagnosis and/or treatment of the patient named above at Ferrell-Whited Physical Therapy Services.

Signature: _____ Date: _____
(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient: □ Self □ Mother □ Father □ Legal Guardian

*ALL INFORMATION ON THIS FORM IS CONFIDENTIAL*

# FERRELL-WHITED PHYSICAL THERAPY FINANCIAL POLICY – 2021

**INSURANCE:** To properly bill your insurance company, we require that you disclose ALL insurance information including primary and secondary insurance, as well as, any change of insurance information. Ferrell-Whited will contact your insurance company prior to services as a courtesy to verify insurance coverage; however, it is not a guarantee of benefits. You are responsible for all charges regardless of your existing medical coverage. If you are not insured by a plan we participate in, you are responsible for out-of-network rates. Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

***Payment for approved services depends on your plan's benefit limitations and eligibility at time of service. Call the Customer Service number on the back of your insurance ID card to learn about what your plan covers, your costs, and to verify your eligibility.**

**NO-SHOW/CANCELLATION POLICY:** We understand there are times when you must miss an appointment due to an emergency. However, your doctor has prescribed physical therapy for you and this is an on-going process which requires regular attendance. If you are late for an appointment, you may have to reschedule or accept an abbreviated treatment for that day. If you cancel/no-show three appointments, FWPT has the right to discharge you from care***. You understand and agree that FWPT requires a 24-hour advance notice of cancellation.*** **IF YOU FAIL TO GIVE 24-HOUR NOTICE OF CANCELLATION OR NO-SHOW AN APPOINTMENT, YOU WILL BE RESPONSIBLE FOR A *$40.00* CHARGE (WHICH IS NOT COVERED BY INSURANCE).**

**DELINQUENT ACCOUNTS/COLLECTIONS:** Outstanding patient responsibilities must be paid by you within 30 days after the date of the invoice sent to you. Failure to pay your invoice within 30 days will result in interest charged on your account in the amount of 2.0% per month. Account balances over 90 days will be sent to collections after no response from the patient. Statements will be mailed once per month for three months before becoming delinquent. **It is the patient's responsibility to inform the staff of any changes in address or insurance information.**

**COPAYMENTS AND DEDUCTIBLES:** All co-pays must be paid at the time of service.

**MEDICARE:** We are a participating Medicare provider. **Per Medicare guidelines patients who are receiving in-home health care are not eligible for outpatient physical therapy services at the same time.** It is your responsibility to inform FWPT immediately if in-home health care services will be utilized at any time during treatment at FWPT.

**WORKERS COMPENSATION:** This office is a certified Ohio Bureau of Worker's Compensation provider and accepts approved claims. Any Disallowed Claim fees will be the patient's responsibility.

**NON-COVERED SERVICES:** Please be aware that some of the services you receive may not be covered by Medicare or other insurers. We will provide you with an advance beneficiary notice (ABN) for any services that Medicare or other insurers will not cover prior to providing the service to you. Such non-covered services will require your prior approval before they are provided. **You are responsible for payment of these services at the time the service is provided.**

**BILLING SERVICE:** Signature Billing Solutions, LLC will be processing all claims and is responsible for sending out patient statements. Please phone our billing service at **330-331-2275** for any questions concerning your statement balances and payments made on your account. Please let the billing office know if you have any difficulties resolving your bill. If your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

**NON-SUFFICIENT CHECKS RETURNED:** For patient payments that are returned due to non-sufficient funds a $35.00 charge will be added to your bill.

FWPT requires patients that wish to make partial payments on a delinquent account to enter into a monthly payment agreement. The agreement requires the patient to make minimum payments to prevent the account from being sent to collections. **The monthly payment must be at or equal to twenty-five percent (25%) of the total outstanding delinquent balance to fulfill the agreement, unless otherwise agreed by FWPT in the partial payment agreement.** All partial payments less than the required minimum submitted shall go towards the balanced owed. However, these insufficient partial payments will not prevent the collections process unless outlined specifically in the payment agreement between FWPT and the patient.

Additionally, FWPT may restrict the scheduling of non-emergent and non-urgent services for individuals with delinquent accounts as deemed necessary.

I agree to be responsible for payment of all services rendered on my behalf or that of my dependents. I acknowledge and accept this Financial Policy.

***PRINT*** Patient Name: _____

***Signature*** of Patient: _____
(*Parent or legal guardian must sign if patient is under 18 years of age.*)

Relationship to Patient: _____ Date: _____

## INSURANCE INFORMATION - 2021

***Primary #1 Insurance Company:*** _____

Principal Policyholder's Name: _____ DOB: _____

ID#: _____ GROUP#: _____

***Secondary #2 Insurance Company:*** _____

Principal Policyholder's Name: _____ DOB: _____

ID#: _____ GROUP#: _____

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Ferrell Whited Physical Therapy Services reserves the right to modify the privacy practices outlined in the notice. I have received a copy of the Notice of Privacy Practices for Ferrell Whited Physical Therapy Services.

***PRINT*** Name of Patient: _____

***Signature*** of Patient: _____
*(Parent or legal guardian must sign if patient is under 18 years of age.)*

Relationship to Patient: _____ Date: _____

***OFFICE USE ONLY***

*Documentation of Attempt to Obtain Acknowledgment of Receipt of Privacy Practices Date: _____*
*The acknowledgment was not obtained because the patient declined to sign the acknowledgment. _____*
*Other Reason: _____*
*Name of Patient: _____Name of FWPT Employee: _____*

## Medical History

**Name:**

### Existing or Relevant Previous Conditions

| | | | | | |
|---|---|---|---|---|---|
| Alzheimers | ◯ Yes ◯ No | Muscular Dystrophy | ◯ Yes ◯ No | Muscular Disease | ◯ Yes ◯ No |
| Cardiovascular Disease | ◯ Yes ◯ No | Obesity | ◯ Yes ◯ No | Osteoporosis | ◯ Yes ◯ No |
| Cauda Equina Syndrome | ◯ Yes ◯ No | Osteoarthritis | ◯ Yes ◯ No | Seizures | ◯ Yes ◯ No |
| Cerebral Vascular Accidnet | ◯ Yes ◯ No | Parkinson's | ◯ Yes ◯ No | Strokes | ◯ Yes ◯ No |
| Current Infection | ◯ Yes ◯ No | Rheumatoid Arthritis | ◯ Yes ◯ No | Tuberculosis | ◯ Yes ◯ No |
| Diabetes Mellitus Type 1 | ◯ Yes ◯ No | Traumatic Brain injury | ◯ Yes ◯ No | Allergies/Asthma | ◯ Yes ◯ No |
| Diabetes Mellitus Type 2 | ◯ Yes ◯ No | | | Pacemaker | ◯ Yes ◯ No |
| Fibromyalgia | ◯ Yes ◯ No | | | Metal Implants | ◯ Yes ◯ No |
| Fracture/Suspected Fracture | ◯ Yes ◯ No | | | HIV/AIDS | ◯ Yes ◯ No |
| High Blood Pressure | ◯ Yes ◯ No | | | Currently Pregnant | ◯ Yes ◯ No |
| History of Cancer | ◯ Yes ◯ No | | | Anxiety | ◯ Yes ◯ No |
| Huntington's | ◯ Yes ◯ No | | | Headaches | ◯ Yes ◯ No |
| Immunosuppression | ◯ Yes ◯ No | | | | |
| Lupus | ◯ Yes ◯ No | | | | |

### Surgical History

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

### Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Additional Information:

_____

_____

_____

_____

_____

_____

_____

_____

_____

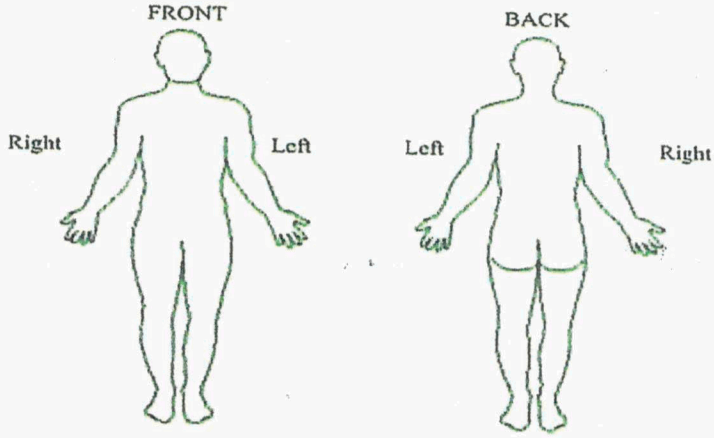
_____

Injury as a result of a fall in the past year? _____

Two or more falls in the last year? _____

## Pain Diagram

- ☆ Shade in affected area(s).
- ☆ Label type of sensation or pain in each area
  Example: Burning, aching, throbbing, stabbing, tingling, numbness, etc.




Draw a line on the pain intensity scale at the point that best describes your pain at the PRESENT time:

_____

0(No Pain) 1 2 3(Mild) 4 5(Moderate) 6 7(Severe) 8 9(Excruciating) 10 (Pain as bad as it could be)

# COVID-19 Treatment Consent Form and Waiver

The undersigned patient is requesting treatment from Ferrell-Whited Physical Therapy Services (the "Clinic") during the COVID-19 outbreak.

The presence of the novel Coronavirus and the resulting COVID-19 pandemic adds additional risk to the treatment I am requesting from the Clinic. There is much to learn about the newly emerged COVID-19 including how it spreads and is transmitted.

Based on what is currently known about COVID-19 the spread is thought to occur mostly from person-to-person via respiratory droplets among close contact. I understand that close contact can occur from being within approximately 6 feet of someone with COVID-19 for a prolonged period of time or by having direct contact with infectious secretions from someone with COVID-19. Carriers of COVID-19 may not show symptoms but may still be highly contagious.

Due to the unknowns of this virus, the difficulty of identifying each and every person who may be infected with the virus, the number of patients who come through the Clinic and the nature of the procedures performed here, ***receiving treatment during this outbreak puts me at an increased risk of contracting the virus***. This risk exists in spite of the enhanced cleaning, sanitation and social distancing protocols being employed by the Clinic to help slow the spread of the virus. In spite of such risk, I specifically request treatment from the Clinic and deliver this consent and waiver in addition to (and not in replacement of) any other consents and/or waiver(s) I have previously delivered to the Clinic in consideration for the treatment provided. By signing below, I acknowledge and agree to all of the following:

I understand that the symptoms listed below are representative of COVID-19:

- Fever
- Dry Cough
- Shortness of Breath
- Temperature
- Persistent pain or pressure in the chest
- Bluish lips or face

In light of the foregoing, ***and as a condition of receiving treatment at this Clinic,*** I certify the following pre-requisites for care (initial each):

_____ I have read the information above and agree to assume the risk of receiving treatment.

_____ My temperature has been taken within 2 hours of arriving at the Clinic and at such time it did not exceed 99.5 Fahrenheit.

_____ At this time, I do not display nor do I currently have any of the symptoms that are representative of COVID-19, which are outlined above.

_____ I have not traveled to any of the countries or regions with widespread ongoing transmission in the past 14 days.

(over)

_____ I have not had close contact with an individual diagnosed with COVID-19 or any individual suffering from any of the symptoms of COVID-19 in the past 14 days.

_____ In the event I am diagnosed with COVID-19 or exhibit two or more of the symptoms above within 14 days of this appointment, I will make a reasonable effort to contact the facility to inform them of this development.

_____ I agree to adhere to appropriate social distancing protocols at all times while at this facility, with the only exception being when I am receiving treatment from a therapist that prohibits observance of such protocols.

I will provide similar certifications upon each subsequent visit during the continuation of the COVID-19 outbreak upon signing in for my scheduled appointment.

***If at the time of any visit you are unable to certify ALL of the foregoing statements, you must leave the Clinic immediately and call to re-schedule your appointment at a later date when such certifications can be made.***

By signing below, I acknowledge the contagious nature of COVID-19 and voluntarily assume the risk that I may be exposed to or infected by COVID-19 by receiving treatment at this Clinic and that such exposure or infection may result in personal injury, illness, permanent disability and/or death to me or a member of my family. I acknowledge that I am voluntarily receiving treatment at the Clinic in spite of such risks and I agree to accept sole responsibility for any injury, illness, damage, loss, claim, liability or expense of any kind suffered by myself or any member of my family that may be incurred in connection with receiving treatment at the Clinic. I hereby release, covenant not to sue, discharge and hold harmless the Clinic, its employees, agents and representatives from and against any of the foregoing of any kind arising out of or relating thereto. This waiver releases the Clinic of any claims based on the actions, omissions or negligence of the Clinic, its employees, agents and representatives, whether a COVID-19 infection occurs before, during or after my treatment at the Clinic.

Patient Name Printed: _____

Patient/Guardian Signature: _____Date: _____