FERRELL-WHITED
PHYSICAL THERAPY SERVICES

PATIENT INFORMATION

Today's Date: _____

Name: _____ SS#: _____/_____/_____

☐Male ☐Female Date of Birth: ____/____/____ Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed

Address: _____
Street Address City State Zip Code

Email Address: _____ Fax: (_____) _____-_____

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

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

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

Driver's License #: _____ State Issued: _____ *Please provide a copy for our records.*

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 SERVICES

FERRELL-WHITED PHYSICAL THERAPY FINANCIAL POLICY - 2018

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).**

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 services will be utilized at any time during treatment at FWPT.

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

SELF PAY/CASH PAY: For the first appointment/evaluation there will be a charge of $140.00. For each follow-up appointment there will be an $80.00 charge per visit. PAYMENT IS DUE AT TIME OF SERVICE.

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.**

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.

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 **330-952-1554** 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.

FERRELL-WHITED PHYSICAL THERAPY FINANCIAL POLICY- 2018 (continued)

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.**

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

Primary #1 Insurance Company: _____

Principal Policyholder's Name: _____ DOB: _____

Secondary #2 Insurance Company: _____

Principal Policyholder's Name: _____ DOB: _____

Third #3 Insurance Company: _____

Principal Policyholder's Name: _____ DOB: _____

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

Existing or Relevant Previous Conditions

Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinsons	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High/Low blood pressure	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ 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:

_____

_____

_____

_____

_____

_____

_____

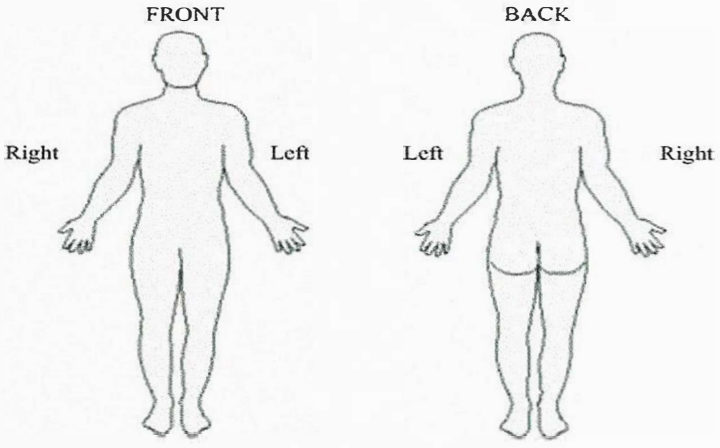
_____

_____

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)