

LONE PEAK PHYSICAL THERAPY

Date: ____ / ____ / ____

Date of Injury: ____ / ____ / ____

Next Appointment w/ Dr. ____ / ____ / ____

Personal Information

Name: _____ Age: _____ Birth Date: ____ / ____ / ____ Sex: M F

SS#: ____ / ____ / ____ E-mail address: _____ Cell Phone: _____

Mailing address: _____

City: _____ State: _____ Zip: _____ Ph: _____

Employer: _____ Ph: _____

Emergency Contact: _____ Ph: _____

IF PATIENT IS A MINOR OR A STUDENT

Parent's Name: _____ Ph: _____

Address: _____ City/ State/ Zip: _____

SSN# _____ Date of Birth: _____

How did you hear about Lone Peak Physical Therapy?

Physician Dr. name: _____

Advertising Where: _____

Friend/Family Whom: _____

ABOUT YOUR INSURANCE- WE WILL NEED COPIES OF ALL INSURANCE CARDS

Primary Insurance: _____ Secondary (if Applicable): _____

If Medicaid: Passport Provider _____

WorkComp Injury: Name of Insurance Co. _____ Adjuster Name/Phone: _____

Date of Injury: ____ / ____ / ____ Claim#: _____

Motor Vehicle Accident: Name of Insurance Co. _____ Adjuster Name/Phone: _____

Date of Injury: ____ / ____ / ____ Claim#: _____

Self Pay- *** Payment due when services are rendered. ***

HIPPA NOTIFICATION

I acknowledge that I have been informed and notified of the whereabouts of Lone Peak Physical Therapy's notice of information practices (how medical information regarding myself may be used and disclosed and how I can get access to this information.)

Signature _____

Date ____ / ____ / ____



PATIENTS WITH INSURANCE:

To file any claims, we must have the correct insurance information, including: the policyholder's name, date of birth and insurance ID#. If you change insurance companies or if your ID# changes, you must provide us with the new information or you will be responsible for all charges on your account.

As a courtesy to you, we will file a claim with your insurance company. If the insurance company only pays a portion of the charges, you will receive a statement with the remaining balance.

If we have not received payment from your insurance company **within 60 days** of the submitted charges, we will apply your co-payments and bill you for the balance. Should your insurance company respond after this, the appropriate step will be taken to ensure the account is paid for and any monies owed to you will be refunded.

We are **participating providers** with the following insurance companies: Blue Cross/Blue Shield, New West, Allegiance, Assurant, Medicare & Medicaid. We also network with Multi Plan and Health Info Net. You are still responsible for any co-payments and deductibles not covered by your plan.

PATIENTS WITH MEDICARE AND MEDICAID:

A referral from your primary care physician is needed to begin treatment with Lone Peak Physical Therapy, Inc. We must have your physician's name and contact information at the time of your first visit.

MEDICARE: If you have a secondary insurance company, we need that information on file. We will bill Medicare for you and you will be responsible for any co-payment charges.

MEDICAID: We need to have your passport provider information on file in order to bill Medicaid for you. Please advise our office if this changes at any time during your care with us.

WORKER'S COMPENSATION OR MOTOR VEHICLE ACCIDENT:

We need a doctor's referral and pre-authorization from your Worker's Comp/ Auto insurance carrier in order to have your visits with us covered. Please provide your Worker's Comp/ Auto insurance company's name, address, phone number and Claim Number at the time of registration. **If we do not have this information, you will be responsible for your charges.**

SELF PAY (no insurance):

You are responsible for paying your bill at the time of your visit. A **Payment Plan** may be set up if it becomes necessary and you qualify. If a payment plan is needed, an appointment must be made with our Billing Manager and the appropriate plan will be put into place. You will receive a 10% discount on payments made on the day of visit.

PATIENTS UNDER 18 YEARS OF AGE:

The **adult accompanying a minor is responsible for payment of the minor's account.** If there is a financial arrangement with another adult for payment of medical bills, we must receive a signed statement from the individual that he/she is responsible for payment of charges.

PATIENTS (over the age of 18) WHEN ANOTHER ADULT IS FINANCIALLY RESPONSIBLE FOR YOU: We must have the financially responsible individual's name, a written statement from that person accepting financial responsibility for your account and an address where we can send your bills. **Otherwise, you will be responsible for payment of your account.**

- **A FEE OF \$50.00 WILL BE CHARGED TO YOU, NOT YOUR INSURANCE, FOR NO SHOW VISITS.**
- **IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, PLEASE PROVIDE 6 HOURS NOTICE; THERE WILL BE A CHARGE OF \$50 FOR LATE CANCELATIONS.**
- **WE TAKE CASH, CHECK, VISA, MASTERCARD, DISCOVER & AMERICAN EXPRESS.**
- **IF A PAYMENT PLAN IS NEEDED YOU CAN MAKE AN APPOINTMENT WITH OUR BILLING MANAGER TO DISCUSS OPTIONS.**
- **IF IT BECOMES NECESSARY TO SEND YOUR ACCOUNT TO COLLECTION FOR NON-PAYMENT, YOU WILL BE RESPONSIBLE FOR ALL COLLECTION AND LEGAL FEES INCURRED.**
- **A COPY OF THIS DOCUMENT CAN BE MADE AVAILABLE AT PATIENT REQUEST.**

I have read and understand the above stated policies, and I have had all my questions answered.

Patient/Guardian Signature

Patient printed Name

Date



CONSENT FOR TREATMENT & AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Lone Peak Physical Therapy Inc., to administer and perform procedures deemed necessary or advisable in the treatment of this patient.

I further authorize Lone Peak Physical Therapy Inc., to release the necessary information requested for insurance or legal purposes, or as requested by an authorized physician. I also authorize release of information from physicians or other health care facilities to Lone Peak Physical Therapy Inc., as needed for physical therapy records.

I recognize that the information disclosed may contain information that is protected by federal and state law, and I specifically consent to disclosure of such information.

AGREEMENT FOR FINANCIAL RESPONSIBILITY

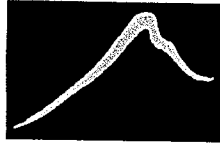
1. I understand that I am financially responsible for payment in full of all charges incurred regardless of insurance coverage. Further, I understand that Lone Peak Physical Therapy, Inc. has no contracted agreement with any private insurance's as those agreements are between the patient and the insurance Co.
2. I hereby authorize payment directly to Lone Peak Physical Therapy Inc., from my insurance carrier, benefits otherwise payable to me, such payment not to exceed Lone Peak Physical Therapy's regular charges for the services performed.
3. If Lone Peak Physical Therapy, Inc. bills my insurance directly, I agree to pay the co-insurance amount that coincides with my insurance policy on a minimum of a monthly basis.
4. If I am unable to make my required payments, a payment schedule will be implemented on the unpaid balance, calling for minimum payments of 33% of this balance. The required payment is negotiable if significant economic constraints are a factor.
5. I understand that there may be some therapy equipment that will not be covered by my insurance Co. I agree to pay for the items not covered.

*As validated by my signature on this form, I certify that I have read and understand the above information:

Date: _____

Patient Name: _____

Signature of Responsible Party: _____



LONE PEAK PHYSICAL THERAPY

Name: _____ Date: _____

1. What major complaint, symptom, or problem brings you here? _____

2. What activities, movements, or positions aggravate your condition? _____

3. What, if anything, relieves your symptoms? _____

4. Is your condition getting better, getting worse, or staying the same? _____

5. Please rate your pain on a scale from 0 to 10:

(Circle a number that represents the best you feel, and a number that represents the worst you feel.)

0 1 2 3 4 5 6 7 8 9 10
No Pain *Worst pain of your life*

6. Please rate your ability to perform your normal activities on a scale from 0 to 10: *(circle one)*

0 1 2 3 4 5 6 7 8 9 10
unable *normal*

7. What tests and/or treatments have you had for this problem? *(x-ray, MRI, chiropractic, etc...)* _____

8. What medications are you currently taking? _____

9. Have you been diagnosed with or experienced any of the following?

- | | | |
|------------------------|---------------------|----------------------------|
| Allergies | Diabetes | Osteoarthritis |
| Balance problems | Dizziness | Psychological condition |
| Bowel/Bladder problems | Headaches | Pregnant/possibly pregnant |
| Cancer: type | High Blood Pressure | Recent weight loss/gain |
| Cardiac Condition | Night Sweats | Rheumatoid Arthritis |
| Chills/Fever/Sweats | Numbness/Tingling | Thyroid Condition |
| Depression | Osteoporosis | Weakness |
| Other: _____ | | |

10. What are your goals for coming to therapy? _____
