



We would like to welcome you to Harper Physical Therapy. Thank you for choosing our office to provide your rehabilitation services. On your scheduled initial appointment please arrive 15 minutes prior to your scheduled time with the following items.

- **Physical therapy prescription (if necessary)**
- **Insurance card(s)**
- **Completed patient paperwork**
- **Form of payment for co-pay/ deductible/ coinsurance (Visa, MC, Amex, Check, Cash)**

A detailed explanation of benefits will be obtained by our office staff within your first 1-2 visits, clearly stating your applicable out of pocket expenses, and coverage restrictions.

Your initial evaluation will last approximately 1 to 1 ½ hours, and will include a comprehensive evaluation, formal assessment of your current condition, and overall expectations/ prognosis. Formal treatment of your condition will be initiated during this first session, so please wear comfortable clothing and athletic shoes. Exposure to your injured area will be necessary for a thorough evaluation and treatment of your condition. Please bring applicable shorts, t-shirts, tank tops, and sports bras for your comfort. Medical gowns are available if needed.

We understand this may be your first interaction with formal physical therapy and/ or dealing with a specific injury. Our goal is to achieve exceptional results or outcomes while providing a fun and enjoyable treatment environment. Please feel free to ask questions as our entire staff at Harper Physical Therapy is focused on guiding you throughout your entire rehabilitation process.

Early and late treatment times are available for your convenience. Kindly provide 24 hrs advanced notice for any cancellations. Please feel free to speak with our office manager regarding any specific issues or concerns throughout your entire course of treatment. We are dedicated to your health, wellness and overall experience with Harper Physical Therapy.

Sincerely,

Ty & Deborah Harper  
Owners

How did you hear about us? Please Circle: Physician Friend Referral Print Ad Internet Other \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Home Phone: \_\_\_\_/\_\_\_\_ Cell Phone: \_\_\_\_/\_\_\_\_ Work Phone: \_\_\_\_/\_\_\_\_

Email \_\_\_\_\_ (Receive monthly health tips and information)

Employer: \_\_\_\_\_ Position: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Wk/Cell/Other \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ Sex: M / F Marital Status: \_\_\_\_\_

If patient is a minor, name of parent/guardian: \_\_\_\_\_ Phone: \_\_\_\_/\_\_\_\_ Is Patient a student? \_\_\_\_\_

Referring Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_/\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_/\_\_\_\_

Date of Injury/onset of symptoms: \_\_\_\_\_ Date of next visit with physician for this injury: \_\_\_\_\_

Date of prescription: \_\_\_\_\_ *\*Please give your prescription to the receptionist*

**If your injury is a work or accident related injury please fill out section below**

Work Related Injury? YES/ NO Accident? YES/ NO Auto? YES/ NO If yes to Auto, what state was accident in ? \_\_\_\_\_

Rehabilitation Nurse / Case Manager: \_\_\_\_\_ Phone: \_\_\_\_/\_\_\_\_ Claim # \_\_\_\_\_

Attorney, If applicable: \_\_\_\_\_ Phone: \_\_\_\_/\_\_\_\_ Fax: \_\_\_\_/\_\_\_\_

Primary Insurance Company: \_\_\_\_\_ Plan type \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_/\_\_\_\_

Policy / Claim Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's SS#: \_\_\_\_\_

Insured's Relation to Patient: \_\_\_\_\_ Insured's Date of Birth: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_ Insured's Work Phone: \_\_\_\_/\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_ Phone: \_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_/\_\_\_\_

Policy / Claim Number: \_\_\_\_\_ Group Number: \_\_\_\_\_



**PATIENT MEDICAL HISTORY**

Name: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Date of first doctor visit for this injury: \_\_\_\_\_

Last date worked due to this injury: \_\_\_\_\_ Date returned to work after this injury: \_\_\_\_\_

Is an Attorney involved in this case? YES NO Have you received home health for this condition? YES NO

Have you had surgery for this injury? YES NO Number of surgeries: 1 2 3 4 \_\_\_\_\_

Type of surgery: \_\_\_\_\_ Took place in: Hospital Surgery Center

Are you currently taking any prescription or non-prescription medications? YES NO

Are you currently taking any of the following : Anti-Inflammatory : Y N Muscle Relaxers : Y N Pain Medication : Y N

List Medications \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Have you had any of the following Medical or Rehabilitative Services for this injury/episode?**

	YES	NO		YES	NO
Chiropractor	_____	_____	CT Scan	_____	_____
EMG/Nerve conduction	_____	_____	General Practitioner	_____	_____
Massage Therapy	_____	_____	MRI	_____	_____
Myelogram	_____	_____	Neurologist	_____	_____
Occupational Therapy	_____	_____	Orthopedist	_____	_____
Physical Therapy	_____	_____	Podiatrist	_____	_____
Emergency Room Care	_____	_____	X-Rays	_____	_____
Other:	_____	_____			

**Do you now have or have you ever had ANY of the following?**

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	_____	_____	Severe or Frequent Headaches	_____	_____
Shortness of Breath/Chest Pain	_____	_____	Vision or Hearing Difficulties	_____	_____
Coronary Heart Disease or Angina	_____	_____	Numbness or Tingling	_____	_____
Do you have a Pacemaker	_____	_____	Dizziness or Fainting	_____	_____
High Blood Pressure	_____	_____	Bowel or Bladder Problems	_____	_____
Heart Attack or Surgery	_____	_____	Weakness	_____	_____
Stroke/TIA	_____	_____	Weight Loss/Energy Loss	_____	_____
Blood Clot/Emboli	_____	_____	Hernia	_____	_____
Epilepsy/Seizures	_____	_____	Varicose Veins	_____	_____
Thyroid Trouble/Goiter	_____	_____	Allergies	_____	_____
Anemia	_____	_____	Any Pins or Metal Implants	_____	_____
Infectious Disease	_____	_____	Joint Replacement	_____	_____
Diabetes	_____	_____	Neck Injury/Surgery	_____	_____
Cancer or Chemotherapy/Radiation	_____	_____	Shoulder Injury/Surgery	_____	_____
Arthritis/swollen joints	_____	_____	Elbow/Hand Injury/Surgery	_____	_____
Osteoporosis	_____	_____	Back Injury/Surgery	_____	_____
Gout	_____	_____	Knee Injury/Surgery	_____	_____
Sleeping Problems/Difficulties	_____	_____	Leg/Ankle/Foot Injury/Surgery	_____	_____
Emotional/Psychological Problems	_____	_____	Are you pregnant?	_____	_____
			Do you smoke?	_____	_____

List any other information that would assist us in your care: \_\_\_\_\_  
 \_\_\_\_\_

Are you aware of what your diagnosis is? YES NO

Based upon your awareness, what are your expectations/goals while in this program: \_\_\_\_\_  
 \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**CONSENT FOR CARE AND TREATMENT**

I, the undersigned, do hereby agree and give my consent for **HARPER PHYSICAL THERAPY** to provide medical care and treatment considered necessary and proper in diagnosing or treating my condition.

Patient \_\_\_\_\_ Date \_\_\_\_\_  
(If patient is under 18 years old Guardian must sign)

**BENEFIT ASSIGNMENT/RELEASE OF INFORMATION**

I, hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payors to **HARPER PHYSICAL THERAPY**. A photocopy of this assignment is to be considered as valid as the original. I, hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Patient \_\_\_\_\_ Date \_\_\_\_\_  
(If patient is under 18 years old Guardian must sign)

**FINANCIAL POLICY STATEMENT**

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal **usual and customary fee** schedule, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to **HARPER PHYSICAL THERAPY**.

The above does not apply for those patients that are considered Worker's Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

**Additional Policies**

All co-pays and deductibles are due at the time of service.

We accept cash, check, MC and Visa.

Finance charge of 1.5 % monthly may be applied to accounts 30 days past due.

Please be advised that if you are paying by check, **HARPER PHYSICAL THERAPY** charges a \$25.00 fee for returned checks.

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

\_\_\_\_\_  
Patient or Guardian/Responsible Party Date

\_\_\_\_\_  
Harper Physical Therapy/Witness Date



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form documents (a) an individual's acknowledgement of receipt of the HPT Notice of Privacy Practices or (b) when unable to obtain this acknowledgement, HPT's good faith effort to do so.

SECTION A: Patient Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

SECTION B: Acknowledgement of Receipt of Notice of Privacy Practices – Please sign

I acknowledge that I have received a Notice of Privacy Practices from Harper Physical Therapy, Inc. I am aware of posted Notice of Privacy Practices in the HPT Lobby.

\*\* Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this acknowledgement is signed by a personal representative on behalf of the individual, complete the following: Personal Representative's Name: \_\_\_\_\_

Relationship to Individual: \_\_\_\_\_

For OFFICE USE ONLY

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Describe why the individual would not/could not sign this form:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Individual

Harper Physical Therapy, Inc.

Table with 4 columns and 5 rows for signature and date information.

Include this acknowledgement of receipt in the individual's medical record.



### **CANCELLATION POLICY**

Because consistent attendance of the planned treatment regimen is paramount to your full recovery, Harper Physical Therapy, Inc. strives to provide each patient with the highest quality of care while attempting to accommodate everyone's busy schedule. In order to minimize waiting time and to assure continuity of treatment, we try to provide reserved time slots for each patient with a specific therapist.

When you cancel an appointment at the last minute or fail to show at all, our ability to accommodate the scheduling needs of our other patients is severely limited. Therefore, we ask your cooperation with the following policy.

- If you are unable to keep a scheduled appointment, please notify us no later than 24 hours prior to your scheduled physical therapy appointment time so that you are able to reschedule.
- If you fail to notify Harper Physical Therapy, Inc. of your inability to make your physical therapy appointment, a \$25 charge will be applied to your bill.

Thank you for your cooperation and consideration for our staff and other patients.

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date