



We would like to welcome you to Harper Physical Therapy. Thank you for choosing our office to provide your rehabilitation services. On your scheduled appointment day 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 the first 1-2 sessions, clearly stating your applicable out of pocket expenses, and coverage restrictions.

Your initial evaluation will last approximately 1 to 1 ½ hours, and includes a comprehensive evaluation, a formal assessment of your current condition, and overall prognosis. Formal treatment of your condition will be started during this initial session, so please wear comfortable clothing and athletic shoes. Exposure to your injured area will be necessary for 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. Please feel free to ask questions as our entire staff at Harper Physical Therapy is focused on providing a professional experience while guiding you through the rehabilitation process.

Early and late treatment times are available for your convenience. Our clinic hours are Monday – Friday 7am to 7pm and Saturday from 7am-3pm. Kindly provide 24 hrs advanced notice for any cancellations. Please feel free to speak with our office manager regarding any issues or concerns throughout your entire course of treatment. Our entire staff is focused on your health, wellness and overall experience with Harper Physical Therapy.

Sincerely,

Ty & Deborah Harper
Owners

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

Last Name: _____ First Name: _____ Middle Initial: _____

Address: _____ City/State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____

Would you like to receive Text message appointment reminders. YES or NO

Email _____ (I give Harper PT permission to add my email address to the email list)

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: _____

Are you receiving or did you receive Home Health ? Who was your Home Health Agency ? _____

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**

Anti-Inflammatory, Muscle Relaxers, Pain Medication

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	_____	_____	Sever 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



**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: _____

Patient Number: _____ 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.**

** 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.

By:		By:	
Print Name:		Print Name:	
		Title:	
Date:		Date:	

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



Patient Rights & Responsibilities

In recognition of our responsibility in rendering patient care, these rights and responsibilities are affirmed in the policies and procedures of Harper Physical Therapy

Patient Rights

- To receive services without regard to race, color, age, gender, sexual orientation, religion, marital status, handicap, national origin or sponsor.
- To be provided reasonable physical access.
- To be provided a safe environment.
- To be provided with appropriate privacy.
- To be treated with respect, consideration and dignity.
- To expect that all disclosures, communications, and records are treated confidentially, except when required by law, and to be given the opportunity to approve or refuse their release.
- To be provided, to the degree known, complete information concerning their diagnosis, treatment and prognosis. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient to be a legally authorized person.
- To be given the opportunity to participate in decisions involving their health care, except when participation is contraindicated for medical reasons.
- To receive from his/her physician information necessary to give informed consent prior to the start of any procedure and/or treatment, except in emergencies. Such information for informed consent should include the specific procedure and/or treatment, significant medical risks involved, and the probable duration of incapacitation. Where significant alternatives for medical care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information and the consequences of not complying with therapy.
- To know the names and professional status of individuals providing service to you and to know the physician primarily responsible for your care.
- To have the appropriate assessment and management of pain
- To be informed, when appropriate, of the treatment policy for minors not accompanied by an adult.
- To refuse treatment and be informed of consequences of refusing treatment or not complying with therapy.
- To be informed as to:
 - Expected conduct and responsibilities as a patient
 - Services available from the facility
 - Provisions for after hours and emergency care
 - Fees for services
 - Payment policies
 - Right to refuse participation in investigational studies or clinical trials
 - Methods for expressing grievance and suggestions to the facility without threat of discrimination or reprisal

- Disclosure of ownership
- To be informed of their rights to change primary or specialty physicians if other qualified physicians are available.
- To be provided with methods of effective communication.
- To review his/her medical record and to have the information explained or interpreted as necessary, except when restricted by law.

Patient Responsibilities

- To demonstrate behavior that shows respect and consideration for other patients, family, visitors, all health care personnel and property of Harper Physical Therapy.
- To provide accurate and complete information about your health history, demographics and insurance information.
- To ask questions and seek clarification until you fully understand.
- To accept the consequences of your actions if you should refuse a treatment or procedure, or if you do not follow the plan of care given to you by the physician or other health care providers.
- To keep appointments, cancel appointments, and notify Harper Physical Therapy of these changes.
- To assure that the financial obligations for health care rendered are paid.
- To notify Harper Physical Therapy of any changes in your medical condition, health history, demographics, and insurance information.
- To be responsible for your valuables that you bring to Harper Physical Therapy.
- To provide positive and negative feedback in a constructive and appropriate manner about the care you have received at Harper Physical Therapy.