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 though the rehabilitation process.

Early and late treatment times are available for your convenience. Our clinic hours are Monday – Thursday 7am to 7pm, Friday 7am to 5pm and Saturday from 7am-2pm. 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

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

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

Home Phone #: _____ Cell Phone #: _____

How would you like to receive your appointment reminders? ( ) Text ( ) Phone Call

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

Employer: _____ Position: _____

Emergency Contact: _____Relationship to Patient: _____ Phone: _____

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: _____

Work Injury? Yes / No **Auto Accident?** Yes / No

How did you hear about us?
Please Circle: Physician Internet Friend/ Family: _____ Other: _____

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

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: _____

Secondary Insurance Company: _____ Phone: _____

Address: _____ Phone: _____

Policy / Claim Number: _____ Group Number: _____

Signature: _____ **Date**_____

PATIENT MEDICAL HISTORY

Name: _____ Date of Birth: _____

Date of first doctor visit for this injury: _____ Last date worked due to this injury: _____

Date returned to work after this injury: _____

Have you had surgery for this injury? YES NO Number of surgeries for this injury: _____ Type of surgery: _____

Have you had 2 or more falls in the past year or any falls with injury in the past year? YES NO

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

Height _____ Weight_____

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:** _____

Physical Therapist Signature: _____ **Date:**_____

MEDICATION LIST

Patient Name: _____Date of Birth: _____

	Name of Medication Rx – Brand & generic name; OTC – Name & active ingredients	**How Much Dosage**	**How to Use / Frequency**	**Why I'm Using / Notes**
***Enter <u>ALL</u> prescription (Rx) medicine (include samples), over-the-counter (OTC) medicine,* vitamin/mineral dietary [nutrition] supplements**				
EX	XXXX/xxxxxxx	40 mg; use two 20 mg pills	Take orally, 2 times a day	
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

❑ Please check box if none

I understand it is my responsibility to notify Harper Physical Therapy staff if there are <u>any</u> changes to my current medication list, including OTC, vitamins and supplements.

Patient Signature: _____ Date: _____

Physical Therapist Signature: _____ Date: _____

****

Meds Reviewed/Updated – Sign: _____ Date_____ PT Initials:_____

Meds Reviewed/Updated – Sign: _____ Date_____ PT Initials:_____

Meds Reviewed/Updated – Sign: _____ Date_____ PT Initials:_____

Meds Reviewed/Updated – Sign: _____ Date_____ PT Initials:_____

Meds Reviewed/Updated – Sign: _____ Date_____ PT Initials:_____

Meds Reviewed/Updated – Sign: _____ Date_____ PT Initials:_____

Patient Health Questionnaire

Name: _____ **DOB:** _____

Over the last two weeks how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
a. Little interest or pleasure in doing things.	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless.	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating.	☐	☐	☐	☐
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching TV.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

Total Score:_____

If you checked off <u>any</u> problem on this questionnaire so far, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Signature: _____ **Date:** _____

WellRx Questionnaire

NAME_____

Questions 1. In the past 2 months, did you or others you live with eat smaller meals or skip meals because you didn't have money for food? _____ Yes _____ No

2. Are you homeless or worried that you might be in the future? _____ Yes _____ No

3. Do you have trouble paying for your utilities (gas, electricity, phone)? _____ Yes _____ No

4. Do you have trouble finding or paying for a ride? _____ Yes _____ No

5. Do you need daycare, or better daycare, for your kids? _____ Yes _____ No

6. Are you unemployed or without a regular income? _____ Yes _____ No

7. Do you need help finding a better job? _____ Yes _____ No

8. Do you need help getting more education? _____ Yes _____ No

9. Are you concerned about someone in your home using drugs or alcohol? _____ Yes _____ No

10. Do you feel unsafe in your daily life? _____ Yes _____ No

11. Is anyone in your home threatening or abusing you? _____ Yes _____ No

The WellRx is a Tool Medicare requires because we are a Medicare contracted facility, all patient over the age of 18 must complete this form to be in compliance with our Medicare Contract.

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.

Signature: _____ Date_____

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.

Signature: _____ Date_____

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.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt of Notice of Privacy Practices – I acknowledge that I have received a Notice of Privacy Practices from Harper Physical Therapy, Inc**.**

Name: _____ Date of Birth: _____

Signature: _____ Date: _____

If this acknowledgement is signed by a personal representative on behalf of the individual, complete the Following:

Representative's Name: _____ Relationship: _____

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 for 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.

I understand that Harper Physical Therapy has a $25 no show fee and a $25 late cancelation fee for all appointments not cancelled 24 hours before my appointment.

Evaluations only: Since we allow for more time during your initial visit; failing to show up to your appointment or cancel appointment within 24 hours will result in a $50 fee.

Signature _____ Date: _____

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

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.