**Health History**

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

First Name Middle Initial Last Name

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

Street Address, City, State, Zip Code

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

Phone Number Email

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

Primary Care Physician Phone

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

Emergency Contact, Name Phone

Current Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Right/ Left Handed (circle) Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Briefly describe the history of the problem: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Was the problem sudden/gradual? \_\_\_\_\_\_\_\_\_\_\_Date of onset?\_\_\_\_\_\_\_\_\_\_\_\_

Where is your pain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of pain are you having? ☐ Dull ☐ Achy ☐ Tingling ☐ Shooting ☐ Stabbing

☐ Burning ☐ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Pain level:\_\_\_\_\_ /10 (10 being pain that would render you hospitalized)

What imaging have you had? \_\_\_\_\_\_\_\_\_\_\_\_\_\_When/what was found?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had previous treatment? If so what type (PT, DC, LMT) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your pain worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

What makes your pain better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

List one activity you would like to be able to do with less pain (what is your goal)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list prescription medication you are taking:

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Circle if you have had any of the following recently:

Numbness/Pins and Needles Changes in bowel or bladder

Fever/Chills/Sweats Pain waking you at night

Weakness/Fatigue Shortness of Breath

Headaches Vision Problems

Unexpected weight loss/gain

Circle if you have a history any of the following:

Osteoporosis Cancer (type) \_\_\_\_\_\_ Heart Problems

Lung Problems High Blood Pressure Pacemaker

Rheumatoid Arthritis Stroke Depression

Anemia Thyroid Problems Diabetes

Multiple Sclerosis Kidney Problems Epilepsy

Parkinson’s Disease Hepatitis Tuberculosis

Surgery (Please list) Other\_\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_

What else is important to you that will impact your treatment, what did we miss above? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Signature

**Consent and Policies**

**Cancelation Policy:** If you need to cancel please give a 24-hour notice, otherwise you will be charged $35.00 for the visit. We realize that there may be times in your life that you are unable to do this, thus we will waive the fee 1 time. \_\_\_\_\_\_\_\_Initials

**Consent to treatment:** Physical therapy involves different types of evaluation and treatment, which may include exercise and hands-on techniques. Through the modalities we use, evaluation and mutual communication our goal is to help you meet your goals. Our goal is to get you moving with less pain.

Physical therapy can have many benefits including increased strength, flexibility, body awareness, endurance and improved ability to perform daily activities with less pain. One may have less pain and improved knowledge about your condition with treatment.

Since people react differently to different types of treatment, it is not always possible to accurately predict your response to treatment. Nor can we guarantee if treatment will help the condition in which you are seeking care. There is inherent risk in exercise, treatment modalities and manual techniques, it may cause pain, injury or aggravate a previous injury.

You have the right to refuse treatment at any time. You have the right to ask questions about the type of treatment you are receiving including the benefits and risks.

**I have read the above statement and consent to physical therapy evaluation and treatment.**

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

Print Name Sign Name

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

Legal Guardian Date

**Payment Agreement**

Thank you for choosing Julie Kay, LLC (doing business as “Mend Physical Therapy”) as your physical therapy provider. Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

* You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.
* Payment is expected at time of service unless we agree to accept assignment from your health plan or other responsible payor and you check the assignment box on the following page or you have made other payment arrangements with us.
* **Out-of-Network Policy for Physical Therapy Services.** (Commercial Health Plans – does not apply to Medicare) If you are receiving physical therapy services and you have out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. You are responsible for contacting your insurance company to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services. On a case-by-case basis, we may, at our sole discretion, agree to accept assignment from your health plan. This means we will bill your health plan for our services directly and await payment from your health plan. If we accept assignment, you agree that if your health plan does not honor the assignment and sends payment to you, you will promptly forward the payments to us. You further agree that if your health plan denies payment of our claims, in whole or in part, you are responsible for paying any and all unpaid amounts within thirty (30) days of receiving our statement.
* **Medicare Policy (for Medicare Part B).** If you are a Medicare beneficiary, you understand that our licensed physical therapists are *not* enrolled as Medicare providers. Medicare has onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide. Since we are not enrolled providers, we cannot submit claims to Medicare *and* Medicare will not pay for our services even though the same services might be paid by Medicare if you obtained them from a Medicare enrolled provider. Therefore, by choosing our services, you are exercising your right to privacy and electing, of your own free will, not to use your Medicare benefits. As such, you are agreeing to pay cash at the time of service for all services you elect to receive from us with no expectation that Medicare will reimburse you. You understand that we will not submit claims to Medicare on your behalf or provide you with a statement or billing codes that you can submit to Medicare yourself. If you want Medicare to pay for services that might be considered covered benefits, you should seek those services from a Medicare enrolled provider. If you decide at any point after you start services with us that you want Medicare to pay for the services it covers, we will be happy to recommend a Medicare enrolled provider and terminate your services with us. You also understand that since we are not enrolled Medicare providers, our services are *not* subject to Medicare’s maximum allowable charge. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare for reimbursement or to obtain a denial for a Medicare supplemental insurance plan.
  + **Medicare supplemental insurance plans.** If your Medicare supplemental insurance plan will reimburse you for medically necessary services by providers not enrolled with Medicare, we will provide you with a letter stating we are not enrolled as a Medicare provider and a statement that you can submit to your supplemental plan. However, you should be prepared that your supplemental plan may not pay for services by providers not enrolled with Medicare. If your supplemental plan requires you to obtain a denial from Medicare before it will pay for your services, we cannot submit a bill to Medicare merely to get a denial because we are not enrolled providers.
  + **Medicare Replacement and Medicare Advantage Plans (“MAP”).** We are not in-network with any Medicare Advantage Plans. If your MAP offers out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your MAP for reimbursement for the services your health plan covers. However, you should be prepared that your MAP may not pay for services by providers not enrolled with Medicare. You are responsible for contacting your MAP to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your MAP denies, in whole or in part, your claims for our services.
  + **Medicare as a Secondary Payer.** If you have a commercial insurance plan, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. However, since we are not Medicare enrolled providers, Medicare will not pay your copays, co-insurance or deductibles as a secondary payer. You understand and agree to carry out whatever procedures are necessary to prevent your commercial insurer from automatically forwarding our bills to Medicare.
* **Auto Liability Claims.** If no-fault insurance coverage is available, we may, at our discretion, agree to accept assignment on your claims, which means we will submit bills to your insurance carrier and they will pay us directly. If the insurance carrier sends payment for our claims to you or your attorney, you agree to cause such payments to be promptly forwarded to us. If the insurance carrier does not pay our claims within a reasonable amount of time or denies our claims, payment will be due within 30 days of receipt of our bill. Alternatively, and unless prohibited by state law, we may wait for payment until your case settles. If we do, you agree to pay the late payment interest fees as stated below and hereby authorize and direct your attorney, adjustor and/or insurance company involved in your case to pay directly to Mend Physical Therapy all sums due and owing for the services you received plus any late payment interest due from any settlement, judgment or verdict rendered in your case. This means you hereby assign and grant a lien to Mend Physical Therapy in any amount sufficient to pay any outstanding balance owed and authorize/require your attorney and/or responsible insurance carrier to recognize and comply with this assignment and lien. You further understand that we are not obligated to discount any portion of our service or interest fees when your case settles regardless of the amount of your settlement, judgment or verdict or whether your settlement, judgment or verdict adequately covers your balance due to us.
* **Wellness & Fitness Services.** Commercial health plans and Medicare do not cover the wellness or fitness services we offer. Therefore, we will provide you with a receipt for these services upon request.
* **Privacy Rights.** You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. If you pay for your services at the time of service, we assume you are exercising this right to privacy we will not disclose your medical records to any third party, including your health insurance carrier or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Authorization to Release Protected Health Information form before we will disclose your health information.
* **Late Payment Penalty.** Unless prohibited by applicable law, a late payment penalty in the amount of 1% per month (12% per year) may be added to your bill for any and all claims that are not paid within thirty (30) days of the invoice or statement date. You agree to be personally responsible for paying this late payment penalty unless the responsible Payor is required to pay such interest under federal, state or other applicable laws.
* **Appeals Policy.** You understand that you are responsible for filing all appeals of adverse benefit determinations. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.
* **Collection Policy.** You understand that we are not required to obtain your written authorization to disclose protected health information to a collection agency or court of law that may be necessary to collect payment for services rendered. Should collection proceedings or other legal action become necessary to collect an overdue account, you will be responsible for paying the collection costs plus court costs and filing fees incurred by the practice.

**I HAVE READ, UNDERSTAND AND AGREE TO THESE PAYMENT TERMS. I acknowledge that I have chosen, of my own free will, to obtain the services provided by Mend Physical Therapy and have agreed to pay out of pocket for my services without any expectation that my health plan will reimburse me. If I am a Medicare beneficiary, I attest that I have chosen not to use my Medicare benefits for the services I am purchasing and am restricting Mend Physical Therapy and my therapist from submitting any claims to Medicare pursuant to my right to privacy under HIPAA.**

X \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Patient and/or Guardian**

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Provider Representative**

A photocopy of this agreement is to be considered valid, the same as if it was the original.