ASSIGNMENT OF BENEFITS FORM

Patient Name: ____

I hereby instruct and direct ______________________________ Insurance Company to pay by check made out and mailed to Doctors of Physical Therapy. If my current policy prohibits direct payment to the provider, I hereby also instruct and direct you to make out the check to me and mail it to the temporary address as follows:

Doctors of Physical Therapy
119 Seaboard Ln #401 Franklin,
TN 37067

For the professional medical therapy benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional therapy services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. The payment will not exceed my indebtness to Doctors of Physical Therapy, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

- I understand I will be legally responsible for any remaining balance, including co-payments and deductibles, not paid by my insurance company.
- I understand that should litigation become necessary; I will be responsible for all Doctors of Physical Therapy legal fees.
- I also understand I will be held responsible for any interest on delinquent accounts and collection fees.
- A photocopy of this Assignment shall be considered as effective and valid as the original.
- I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.
- I authorize Doctors of Physical Therapy to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature of the Policy Holder: ______________________________ Date: ____________________

Witness: ____ Date: ____________________

DIRECT ACCESS CONSENT FORM

PATIENT NAME: ____

AREA OF PAIN: ____

Have you been seen by a physician for this complaint in the past 12 months? YES NO

- If yes, the therapist will notify this physician of the finding of this evaluation
    - Please list the physicians name and telephone number: ______________________
    - Treatment may not continue beyond 6 visits without certification of the physician.

If no, would you like your treating therapist to notify a physician of your evaluation findings? YES NO

- If yes, please list the physicians name and telephone number:

  ____

- Treatment may be initiated for 15 visits or 3 months from your evaluation date, but may not continue beyond 15 visits or 3 months without certification from a physician.
- If no, treatment will continue for 15 visits or 3 months for your evaluation date, whichever comes first, and a list of appropriate referral options will be discussed.
    - If at 15 visits or 3 months from your evaluation date there is no progress being made with treatment, and treatment may continue up to 30 days.
    - At 3 months, the patient will be discharged or referred to an appropriate physician as discussed upon the evaluation date.

____

Patient Signature **Date**

CANCELLATION POLICY

Your appointment time is reserved especially for you, and we make sure to focus the entire appointment on you and your needs. If you are running late, please understand that we cannot extend your appointment time as that will take away time from the patient whose appointment is booked after yours. If you need to cancel, please provide at least 24 hour's notice, so that we may accommodate others who are waiting for an appointment.

The patient is responsible up to $150 Fee for a 1 hour appointment or $75 fee for a 30-minute appointment for late cancellations or missed appointments. We do not take cancellations on the weekend for Monday appointments.

PATIENT SIGNATURE ____

TODAY'S DATE ____

Agency Consent to Treat

Patient Name: ____

Authorization for Treatment

I consent and authorize Doctors of Physical Therapy., (the "Rehab Agency1') to provide physical, occupational and/or speech therapy as ordered by my physician.

Release of Information

This authorization, or copy of same, authorizes the release to the Rehab Agency of any medical information necessary for treatment and/or to process claims for services rendered by the Rehab Agency.

Patient or authorized patient representative agree to execute any documents and perform any acts that the Rehab Agency may reasonably request with regards to therapy services.

The undersigned warrants and represents that attached hereto are originals or certified copies of any applicable powers of attorney, health care surrogate forms or court orders appointing the undersigned as the legal guardian of the patient.

Reimbursement Coverage

The patient or authorized patient representative hereby assigns to the Rehab Agency all private medical insurance benefits (primary and secondary, including Medigap providers) or other benefits to which patient may be entitled, for any therapy services rendered by the Rehab Agency.

The patient or authorized patient representative authorizes and directs the Rehab Agency to apply and file for all such benefits on behalf of patient.

Both the patient and/or patient representative agree that in consideration for the services rendered to the patient, an obligation exists for charges incurred during these treatments, in accordance with the regular rates and terms of the Agency. Should this account be referred to collections, the patient shall be responsible for reasonable fees associated with collections, including reasonable attorney's fees (if applicable). All delinquent accounts shall bear interest at the legal rate. This guarantee/obligation shall include any charges not covered by insurance, Medicare and/or when Medicare Lifetime Reserve Days are not authorized to be billed.

The patient or authorized patient representative authorizes the Rehab Agency to represent the patient during the appeals process in the event of a denial of Medicare benefits.

Term

This patient consent and authorization given to the Rehab Agency as set forth above will remain in full force and effect per episode of care (initial assessment to discharge) until terminated in writing by patient or authorized patient representative. This termination will not be effective until the facility receives this request writing.

______________________________ ______________

PATIENT SIGNATURE **DATE**

______________________________ ______________

PATIENT REPRESENTATIVE SIGNATURE **DATE**

INTEGRATIVE DRY NEEDLING CONSENT FORM

Integrative dry needling involves placing a small needle into the tissue that is tender with the intent to normalize the physiology of the area and regain homeostasis, which will improve the function of the musculoskeletal system resulting in symptom reduction.

Integrative dry needling is a valuable treatment for musculoskeletal pain. Like any treatment there are possible complications; while these are rare, they are real and must be considered prior to giving consent to treatment.

Risks of the Procedure: Though unlikely, there are risks associated with this treatment. The most serious risk associated with dry needling is accidental puncture of the lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and in skilled hands should not be a concern.

Other risks may include bruising, infection, and nerve injury. Please notify your provider if you have any conditions that can be transferred by blood. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from dry needling in unlikely.

Please consult with your practitioner if you have any questions regarding the treatment above.

Do you have any known disease or infection that can be transmitted through bodily fluids?
_____ Yes _____ No If you marked yes, please discuss with your practitioner.

Please print your name to indicate you have read this form and consent to treatment.

Signature ______________________________ Date ______________________

Financial Policy

Insurance

Doctors Physical Therapy is an in-network provider for Medicare, Aetna and most BCBS PPO plans. For most other insurance plans, we are out-of-network providers. Regardless of whether we are in or out of network with your insurance plan, we can help you understand your benefits so that you know how physical therapy is covered. However, the patient is ultimately fully responsible for knowing his/her own insurance benefits and verification is not a guarantee of payment by the insurance company. Please understand that your insurance coverage is a contract between you and your insurance carrier and we are not a party to that contract. As a courtesy, we will directly bill your health, auto or worker's compensation insurance companies. If an insurance problem occurs, you may be asked to assist us in contacting your insurance carrier.

Your Financial Obligations

We accept Apple/Google/Samsung Pay, Visa, MasterCard, debit, checks, and cash. There is a $25 fee for all returned checks. If you have insurance, you are responsible for the following:

- Your co-pay/coinsurance at the time of service (per your insurance plan)
- As a courtesy, patients with multiple visits in a week can pay on a weekly basis.
- Deductibles your insurance carrier applies to your coverage.
- Any other portion of your bill that is denied or not paid by your insurance carrier.

If you choose to do self-pay, we offer a reduced rate if payment is made at the time of your visit. This cannot be billed to your insurance. Most insurance companies do not reimburse for medical supplies (such as home exercise equipment or shoe inserts). Payment for these items is expected when you receive them. Unless you have already paid us in full, any money paid to *you* by your insurance company for services billed and rendered by Doctors of Physical Therapy shall be paid to Doctors of Physical Therapy immediately upon receipt. Should it become necessary to forward your account to an outside collections' agency, you will be responsible for any associated collection, legal, or court fees.

Authorizations *(please initial next to each statement and sign below)*

__________ I have read Doctors of Physical Therapy financial policy and agree to comply.

__________ I understand how insurance verification and billing works (if I am in network or out of network).

__________ I authorize payment of medical benefits from my insurance directly to Doctors of Physical Therapy.

__________ I authorize the release of all medical records to referring physicians and my insurance company.

__________ I agree to accept full financial responsibility for any balance on my account that is not paid by my insurance.

__________ Doctors of Physical Therapy has informed me of and provided me with a copy of my rights (Notice of Privacy Practices) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

____   ______________

Patient Signature   *(parent/ guardian must sign if patient is a minor)*   Date

Mary Claire Aaron
PHYSICAL THERAPY
MOVE BETTER. MOVE FORWARD.

New Patient Form

Patient's Name: ______________________ Date of Birth: __________

Home Address: ______________________

City: ______________ State: _____ Zip Code: __________ __________

Cell Phone: __________ Home Phone: __________ Email: __________

Emergency Contact Name: ______________________ Phone: __________

Marital Status: Married Single Widowed Student

Employer Name: ______________________ Employer Phone: __________

Employer Address: __________ City: __________ State: _____ Zip Code: __________

May we contact you in any of the following ways? Email address: __________

Text: __________ Call: __________ Voicemail: __________

May we use photographs that you may be in for marketing/advertising? Yes No

When was your date of injury? __________ When do you return to your doctor? __________

Auto related: Yes No Work related: Yes No Other: Yes No

What name would you like to be called? ______________________

Insurance Policy Holder Information

Does this insurance policy belong to: Self Spouse Parent Other

Policyholder's name: ______________________

Policy holder's Date of Birth: ______________________

How did you hear about us (please circle all that apply): Google Facebook LinkedIn Instagram Friend Website Event Doctor Returning Patient Other

I understand it is my responsibility to provide any additional information such as: living wills, medical records, do not resuscitate (DNR) orders, etc.

HIPPA Policy: The HIIPA policy was offered to me. I am aware and understand the policy and are aware copies of the policy are available upon request. Please list anyone we would need to discuss your health or financial records with: (Please note, we will not share your information with anyone unless listed.)

Name: ______________________ Relationship to you: __________

Signature: ______________________ Date: __________

Guardian signature (if minor): ______________________ Date: __________

Mary Claire Aaron
PHYSICAL THERAPY

MOVE BETTER. MOVE FORWARD.

Patient Registration Form

Patient Information

Patient Name (first, middle initial, last)				Prefers to be Called
Date of Birth	Age	M/F	Is patient a minor?	If so, name of Primary Parent/Guardian Contact

Please list your phone numbers and select phone type in the order you would like to be called:

1. ______ ☐ home ☐ work ☐ cell
2. ______ ☐ home ☐ work ☐ cell
3. ______ ☐ home ☐ work ☐ cell

Select the locations where we can leave you messages that may contain health information: ☐ home ☐ work ☐ cell ☐ email	Email address		
Home Address	City	State	Zip Code

Occupation	Employer	
Emergency Contact Name	Relationship	Phone Number
Person Responsible for Bill	Relationship to Patient	Address (if different)

How did you hear about us?	Is your injury related to an auto accident? ○Yes ○No Is your injury related to an accident at work? ○Yes ○No

Referral Information

Do you have a prescription? ☐ Yes ☐ No	Referring Doctor	Have you seen a doctor at any time for this injury/pain?
Is there anyone other than your referring physician to whom you would like us to fax your evaluation?		

Primary Insurance Information

Insurance Company Name	Policy Number		Group Number
Subscriber's Name (if different than self)	Relationship to Patient	Birthdate	

Secondary Insurance (if applicable)

Insurance Company Name	Policy Number		Group Number
Subscriber's Name (if different than self)	Relationship to Patient	Birthdate	

I consent to treatment necessary for the care of the above named client.

______________________ ______________

Patient Signature — Date

(If patient is a minor, parent or guardian's signature required)

Medical History Intake Form

Patient Name (first, middle initial, last)	Date

Current Condition

Briefly Describe Your Problem (including where you are experiencing pain)	Date of Onset

Did the pain/problem begin:

☐ gradually ☐ suddenly

If this episode began suddenly, what action was involved?

Have you had prior episodes of this pain/problem? ☐ Yes ☐ No

If yes, how many episodes have you had? ______

When did the first episode begin? ______________

Is this episode worse than the previous episode? ☐ Yes ☐ No

List activities that you can NOT do because of your current problem:

Please check the activities that affect the pain/problem:

	No Change	Better	Worse		No Change	Better	Worse
☐ Standing	○	○	○	☐ Squatting	○	○	○
☐ Sitting	○	○	○	☐ Kneeling	○	○	○
☐ Walking	○	○	○	☐ Bending Backward	○	○	○
☐ Lifting	○	○	○	☐ Bending Forward	○	○	○
☐ Pushing/Pulling	○	○	○	☐ Typing/Writing	○	○	○
☐ Overhead Reaching	○	○	○	☐ Driving	○	○	○
☐ Lying on Stomach	○	○	○	☐ Coughing	○	○	○
☐ Lying on Back	○	○	○	☐ Sneezing	○	○	○

Which special tests have been performed for your current problem?

	Date	Area of Body/Brief Description of Results
☐ X-Rays	________	________________________________
☐ Bone Scan	________	________________________________
☐ MRI	________	________________________________
☐ CAT Scan	________	________________________________
☐ Myelogram	________	________________________________
☐ EMG/NCS	________	________________________________
☐ Epidural Steroid Injection	________	________________________________
☐ Nerve Root Block	________	________________________________
☐ Facet Joint Injection	________	________________________________
☐ Other	________	________________________________

Have you had surgery for <u>this</u> problem? ☐ Yes ☐ No

If yes, please answer the following:

Surgery Type	Date	Since the surgery do you feel :	Describe the change:
	________	○ Better ○ Worse ○ Same	________________

Current Condition *Continued*

Please select the number that best represents your *average* pain (0= no pain, 10=worst pain):

	0	1	2	3	4	5	6	7	8	9	10
What is the least?	O	O	O	O	O	O	O	O	O	O	O
What is the worst?	O	O	O	O	O	O	O	O	O	O	O
What is it today?	O	O	O	O	O	O	O	O	O	O	O

Goals for Physical Therapy: Please list your goals for physical therapy (ex. To return to playing tennis, to get dressed without pain etc.)

____

____

____

____

Medical History

Medical History (please check all that apply to you)

- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Circulation Disease
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Breathing Problems
- ☐ Thyroid Condition
- ☐ Allergies
- ☐ Recurrent muscle joint pain problems
- ☐ Infectious disease (HIV, Hepatitis, etc.)
- ☐ Currently pregnant or attempting pregnancy
- ☐ Other ______________________________

Current Medications: ______________________________

____

Therapy History:

If you have had physical therapy in the past (for this or another injury) please list where, when and for how long you attended:

____

____

____

Please check the types of treatment you have received (at any time) and indicate how it affected your pain/problem:

	No Change	Better	Worse
☐ Hot Packs	O	O	O
☐ Ice/Cold Treatments	O	O	O
☐ Ultrasound	O	O	O
☐ Massage	O	O	O
☐ Myofascial Release	O	O	O
☐ Craniosacral Therapy	O	O	O
☐ Electrical Stimulation	O	O	O

	No Change	Better	Worse
☐ Chiropractic/Adjustments	O	O	O
☐ Acupuncture	O	O	O
☐ Bracing/Splinting	O	O	O
☐ Strengthening Exercises	O	O	O
☐ Flexibility Exercises	O	O	O
☐ Traction	O	O	O

Are you currently receiving any of these treatments? ☐ Yes ☐ No

Medical History Continued

Surgery History: Please list any surgeries you have had for other musculoskeletal problems

Surgery Type	Date	Since the surgery do you feel: Better	Worse	Same	Describe the change:
______		O	O	O	______
______		O	O	O	______
______		O	O	O	______

Personal History

In this section we are trying to assess areas of your daily life that could impact your symptoms or your therapy. Please list information that you think is significant and relevant.

Regular Exercise (what type and how often):

____

____

Fluid Intake per Day: ______________

Dietary Habits (ex. caffeine, alcohol, citrus, nutrisweet, servings of fruits/vegetables):

____

____

Sleep Habits (ex. trouble falling asleep or staying asleep): ______

Average Activity Level (ex. Spend work day sitting at a desk):

____

____

Are there any other comments or questions that have not been addressed above?