CORE 3 PHYSICAL THERAPY

PATIENT FINANCIAL RESPONSIBILITY

I expressly guarantee full payment of this account for all services rendered by CORE 3 PT. Regardless of my quoted insurance benefits, I understand that I am fully responsible for all charges incurred. I understand the below prices are approximations and the actual cost of my visits could vary. I understand that the actual cost of my appointments will be determined by my insurance company. CORE 3 PT will file all claims to my insurance carrier and my insurance carrier will either: 1) reimburse CORE 3 PT directly if they are in-network with my insurance plan, or 2) reimburse me for these services and I am then responsible to remit payment in full to CORE 3 PT. If I have insurance benefits for physical therapy, I am expected to remit payment for my quoted deductible balance, coinsurance, and/or copayment. If I do not have insurance coverage, I understand that the payment is due in full to CORE 3 PT at the time of service.

☐ Without providing your insurance information before your appointment, Core 3 PT cannot estimate the cost of your appointments. You are responsible for any copay/coinsurance determined by your insurance.

Does the patient have a deductible? **Reset Date:**_____

YES

The remaining balance of the deductible is: _____
Approximate cost of initial evaluation:_____
Approximate cost of follow up visits:_____
Once deductible is met, cost of follow up visits:_____

NO

Cost of initial visit:_____
Cost of follow up visits:_____ **Visit Limit:**_____

For payments via credit card, we impose a surcharge that is not greater than our cost of acceptance (3%). You can use a debit card, HSA card, check, or cash if you prefer. For cash payments we can only accept exact amounts, but can apply excess payment to future visit costs.

I authorize CORE 3 Physical Therapy to keep a credit card on file and charge it for charges incurred, including same day cancellation and no show fees.

SIGN:_____**DATE:**_____

PRINT NAME:_____

CORE 3 PHYSICAL THERAPY

PATIENT CONSENT

Please read and sign below if agreeing that all information provided herein is true and correct:

Consent to Treatment: I consent to physical therapy treatment at CORE 3 Physical Therapy LLC (CORE 3 PT) under the prescription of my referring physician or my physical therapist via direct access.

Information Release: I give permission to CORE 3 PT to release information, verbal and written, contained in my medical record and other related information to my physician, insurance company, rehabilitation nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons.

Privacy of Information: I acknowledge that CORE 3 PT has made available a copy of their HIPAA Privacy Policy, located in the waiting area of the clinic. A copy may be obtained for my records by request. Information without patient identifiers may only be used for quality assurance and/or outcomes purposes (i.e. research).

Medicare Patients I am responsible for my annual deductible, any remaining balance after Medicare and my supplement have paid. I have been informed that Medicare does not allow for any overlap of outpatient physical therapy with home health care and/or services provided at a skilled nursing facility. It is my responsibility to confirm my home health discharge date. I am responsible for all charges denied by Medicare that overlap with home health care.

Auto Insurance Patients: CORE 3 PT will bill all claims to either my confirmed auto carrier and/or my health insurance for charges related to an auto accident. It is my responsibility to inform CORE 3 PT if my auto insurance medical benefits have been exhausted at any time during my course of treatment with CORE 3 PT. My auto insurance carrier will not inform CORE 3 PT when I reach or exceed the medical benefit. I am required to provide a copy of the letter to CORE 3 PT that I will receive at home stating my benefits have been exhausted. I am responsible for all unpaid balances, including all deductible, coinsurance or copayments at the time of service.

Cancellation Policy: I understand CORE 3 PT reserves the right to reschedule my appointment if I am more than 15 minutes late. I acknowledge that appointment times are valuable and by giving last minute notice I prevent someone else from being able to schedule that time slot.

I understand that CORE 3 PT reserves the right to charge a $50 fee if I fail to cancel an appointment with at least 24 hours notice or fail to show up for my appointment.

SIGN :_____**DATE:**_____

PRINT NAME:_____

CORE3 PHYSICAL THERAPY

PATIENT HISTORY

Patient Name: _____

Referring Healthcare Provider: _____
(physician, nurse practitioner, midwife, etc.)

Primary Healthcare Provider: _____

OBGYN (if applicable): _____

What injury/symptoms are we seeing you for? _____

What was the cause of your injury/symptoms? _____

Have you ever had these symptoms in the past? YES or NO
If you circled YES for the same or similar symptoms, who did you see?

_____

Are you currently being treated for your symptoms? YES or NO
If YES circle which apply:
Chiropractor Medical Doctor Physical Therapist

What tests have you had for your symptoms and when were they performed?

X RAY _____ MRI_____ CT _____ EMG_____ OTHER: _____

Please list any surgeries or treatment you have previously received:

_____

Have you had any falls in the past year? _____

Any new medications since your last visit?_____

What is your goal for therapy? _____

Rate your pain over the last 2 weeks from 0—10 0 = None 10 = Extreme

Best: _____ Worst: _____ Current: _____

CORE3 PHYSICAL THERAPY

PATIENT HISTORY CONTINUED

Any allergies? _____

Please list all current Medications, Supplements, and Vitamins being taken at this time:

Do you have any of the following? Check all that apply:

- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Chest Pain/Angina
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Pacemaker
- ☐ Asthma
- ☐ Heart Palpitations
- ☐ Stroke/CVA
- ☐ Liver/ Gallbladder Problems
- ☐ Kidney Problems
- ☐ Bowel/ BladderAbnormality
- ☐ Difficulty emptying bladder
- ☐ Painful urination
- ☐ Urine Leakage
- ☐ Constipation
- ☐ Recent Fractures or Surgeries
- ☐ Metal Implants
- ☐ Seizures
- ☐ Dizziness/Fainting
- ☐ Nausea/Vomiting
- ☐ Special Diet Guidelines
- ☐ Hernia
- ☐ Are you pregnant?
- ☐ Rheumatoid Arthritis
- ☐ Osteoporosis
- ☐ Ringing in your ears
- ☐ Headaches
- ☐ Cancer or History of Cancer
- ☐ Smoking
- ☐ Skin Abnormalities
- ☐ Other_____

PATIENT DEMOGRAPHICS

If you are a returning patient, please update any of the following information that has changed since your last visit with CORE 3 PT

☐ Check the box if all information is the same.

Patient Name: _____ Pronouns: _____

Date of Birth:_____Occupation:_____

Age: _____ Height: _____ Weight: _____ Sex: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone # (cell): _____ Phone # (home): _____

*Which number(s) is our staff authorized to leave phone messages? (please circle) Home Cell

Email: _____

How did you hear about us?

- ❑ Physician
- ❑ Friend/Family
- ❑ Website
- ❑ BNI Referral
- ❑ Other_____
- ❑ Live Talk
- ❑ Facebook
- ❑ Instagram
- ❑ Google Search

Emergency Contact: _____

Relationship: _____Phone #: _____

☐ Check the box to allow the above contact to receive your medical information from CORE 3.