BODYCENTRAL
Physical Therapy

www.BodycentralPT.net

PATIENT VERIFICATION/BENEFITS FORM

Your insurance company gave us the following information regarding your benefits:

Co-pay Amount per Visit: _____

Deductible Amount: _____

Co-insurance per Visit: _____

Based on the information your insurance company provided, we have calculated the amount you need to pay at each visit. Please note, if you have a deductible or a coinsurance, we are estimating the amount you will owe based on your insurance company's contract with our office. We will estimate this to the best of our ability, but please be aware that you may owe additional money.

Medical Supplies- cold packs, resistance bands, K-tape, pulleys, foam roller, and massage sticks are available for purchase with cash, check or credit card. Unfortunately, supplies are not covered by your insurance plan.

Please note that cancellations and no-shows are not covered by your insurance plan.

Estimated payment to be paid at each visit: _____

I understand that this is an estimated payment for services, and that I may be responsible for additional amounts based on my insurance payments and benefits. I understand that my benefits are determined by my insurance company and that Bodycentral Physical Therapy is not financially responsible for benefits that are not covered under my plan. If I overpay on my account, I understand that I will be refunded the overpayment amount directly and that I will receive this payment promptly within 30 days of my request for the refund.

Patient Name Printed: _____

Witness: _____

Signature_____ Date_____

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WELCOME TO OUR PRACTICE!

Please allow us to extend a warm welcome to you and thank you for choosing all of us at Bodycentral Physical Therapy to help you with your aches, pains and other things that bring you to us. There are a lot of choices for Physical Therapy in Tucson, and we do appreciate your business.

As an added bonus to coming to our practice, we provide a free Newsletter to all of our patients with tips on how to exercise correctly, healthy eating ideas as well as some recipes, and other great information on injury management and health. We also like to invite you to all our fun events and our community activities that we do throughout the year.

To sign up for this, all we need is your email address. We send a newsletter out twice a month—on the first and third Monday. If at any time you choose not to receive this newsletter, there is an opt-out button at the bottom. We also have a "share" button that you can use to send the newsletter to your friends or anyone else that might benefit from the information.

If you like our services, please feel free to share your experiences on Yelp.com, Facebook or any other online service you like.

If you have any issues or are not 100% satisfied with your experience with us, please tell us! We are happy to work with you to resolve any issues and make your time with us enjoyable. Therapy can be hard work, but there is absolutely no reason why you cannot have a little fun along the way. We are always looking for ways to improve, and your input is vital to that.

____ Yes! Sign me up for the newsletter. My email is:

_____

____ No thanks, I do not want to sign up at this time.

Signature_____ Date_____

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PATIENT INFORMATION

Last Name: ______________________ First Name: _______________________ MI: ___ M/F _____

Address: __________________________________ City/State/Zip:__________________________

Home Phone #: ______________ Cell Phone #: _______________ Email:_____________________

Date of Birth: ______________ SSN#: ________________ Referring Physician: ________________

Primary Care Physician, if other than referring Physician: ____________________________________

Employer: _____________________ Occupation: _________________ Work Phone: ____________

Emergency Contact: ______________ Phone #: _______________ Relationship: _______________

**************************BILLING & INSURANCE INFORMATION***********************

Primary Insurance: _______________________________ Policy #: ____________________

Relationship to the Insured for Primary Insurance: Self Spouse Child Other: ________

Policy Holder Name: _________________________________ DOB:_______________

Secondary Insurance: ______________________________ Policy #: ____________________

Relationship to the Insured for Secondary Insurance: Self Spouse Child Other: ________

Policy Holder Name: _________________________________ DOB:_______________ **IF**

OTHER THAN ABOVE:

Related to Work Injury or Automobile: Yes or No_______ If Yes, Date of Injury: ________________

Attorney Name: _________________ Attorney Phone Number: _____________________________

Claim #: _____________________ Auto – Do you have MedPay on Policy: ___________________

Are you presently receiving Home Health Care? ___________ Name of Agency: ___________________

HIPAA

I have been offered a copy of the notice of privacy practices and have accepted or denied the offer. I give my consent that my health information can be used for the purpose of treatment, payment, and health care operations.

**************************************PAYMENT POLICY*********************************

I authorize payment to be made and/or sent directly to BODYCENTRAL Physical Therapy. I agree to be responsible for any unpaid balances for services rendered. I agree to pay my deductible and/or copayment upon each visit. I understand that obtaining any necessary insurance referrals from my referring physician is my responsibility.

Signature____ Date______________________

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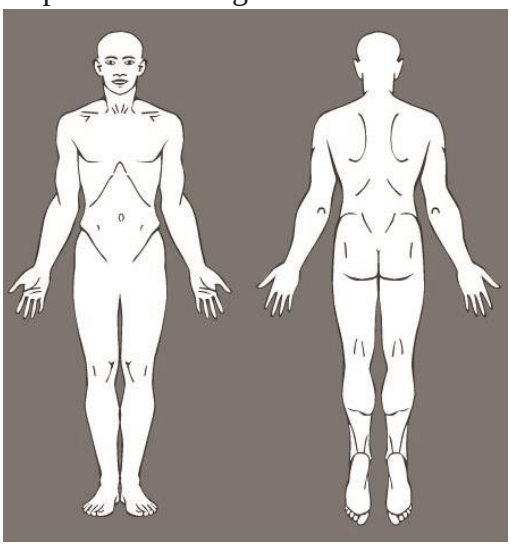
If the bill is sent to our collections agency, I further agree to pay the cost of collections. This includes all reasonable attorneys' fees for all unpaid bills submitted.

PATIENT MEDICAL HISTORY

Please mark the location of your current pain on the diagram below:



Date of injury: _____

What caused your injury/symptoms? _____

Circle the word that describes your pain: Sharp Burning Aching Numbness Tingling Throbbing

What aggravates your pain:

_____

What relieves your pain:

_____

Rate Your Pain Below: 0=No pain 10=Extreme pain

At its worst in the past 3 days: 0 1 2 3 4 5 6 7 8 9 10

Right Now: 0 1 2 3 4 5 6 7 8 9 10

At its best in the past 3 days: 0 1 2 3 4 5 6 7 8 9 10

Signature_____ Date_____

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Have you had a fall in the last year? Yes No If yes, was there an injury? _____

What are your goals/expectations from physical therapy? _____

PATIENT MEDICAL HISTORY

Do you have any of the following?

Yes No Coronary Artery Disease
Yes No Congestive Heart Failure
Yes No High Blood Pressure
Yes No Cancer/Type _____
Yes No Diabetes Type I/II _____
Yes No Blood Clot/Emboli
Yes No Epilepsy/Seizures
Yes No Thyroid Disease
Yes No Kidney Disease
No Anemia
Yes No Headaches
No Dizziness/Fainting
Yes No Unexplained Weight Loss/Gain
Yes No Stroke/TIA
Yes
Yes
Yes No

Yes No Osteoporosis/Osteopenia
Yes No Infectious Disease
Yes No Osteoarthritis
Yes No Rheumatoid Arthritis
Yes No Fibromyalgia
Yes No Multiple Sclerosis
Yes No Vision Changes
Yes No Do you smoke?
Yes No Are you pregnant?____weeks Yes No Do have a latex allergy?
Yes No Do you have other allergies?
Other: _____

Height: _____ Weight: _____

PELVIC HEALTH (if applicable):

No
No Vaginal Delivery: #_____
No
No C-Section: # _____
Yes No
Yes No Episiotomy: # _____
Yes No
Yes Prolapse or organ falling out
Yes
Yes Painful intercourse
Yes
Yes Trouble initiating urine stream
Urinary or fecal leakage

Yes No Pelvic Pain
Yes No Painful periods
Yes No Menopause: when? _____
Yes No Recurrent bladder infections
Yes No Constipation/straining
Yes No Trouble feeling bowel urge
Other: _____

Have you had surgery for this injury? Yes No If yes, date and type of surgery: _____

Signature_____ Date_____

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Other surgeries: _____

_____

Diagnostic tests (Xray, MRI, Ultrasound, NCV, etc):_____

List of your current prescription and/or non-prescription medications (or bring in list):

Name	Frequency	Dosage	Route (oral, etc)

CONDITIONS & CONSENT FOR PHYSICAL THERAPY

1. COOPERATION WITH TREATMENT:

I understand that in order for physical therapy to be effective I must attend scheduled appointments. I understand that I may be discharged from physical therapy if I do not attend two (2) appointments without calling to cancel or reschedule. I agree to cooperate with the home program assigned to me. If I have difficulty, I will discuss it with my therapist.

2. NO WARRANTY:

BODYCENTRAL Physical Therapy does not promise a cure for my condition. The staff will share with me the available statistics and studies regarding results of physical therapy treatment for my condition. They will discuss all treatment options with me.

3. INFORMED CONSENT TO TREATMENT:

The term "informed consent" means that the potential risks, benefits and alternatives of physical therapy treatment have been explained to you. BODYCENTRAL Physical Therapy provides a wide scope of services and you will receive information at the initial visit on the treatment/assessment options available for your condition.

A. Potential Risks:

You may experience an increase in your current level of pain or discomfort or an aggravation of your existing injury. This discomfort is usually temporary and will probably subside in 24 hours.

B. Potential Benefits:

Benefits include an improvement in your symptoms and an increase in your ability to perform your daily activities. You may experience increased strength, awareness, flexibility

Signature_____ Date_____

and endurance in your movements. You may experience decreased pain and discomfort. You will have greater knowledge to manage your condition. C. Alternatives:
All physical therapy treatment options available for your condition will be explained to you. You may inquire on the cost of these services and discuss them with your therapist. If you do not wish to participate in the therapy program, you may discuss your medical, surgical or pharmacological alternatives with your physician.

I have read or had read to me the foregoing and any questions have been answered to my satisfaction. I understand the risks, benefits and alternatives of the treatment. I voluntarily consent to physical therapy treatment. I understand that I may withdraw at any time.

CANCELLATIONS AND NO-SHOWS

We take this subject seriously at each clinic because it can make the difference in whether you succeed in treatment or not. Your doctor and/or therapist have prescribed a set frequency for treatment. Showing up as scheduled for these visits is your most important job.

- We require 24 hours notice in the event of a cancellation. It is your responsibility to have an alternative time in mind to ensure you attend the fully prescribed number of treatments that week.
- **There is a $25 charge for cancellation without 24-hour notice.** This charge will not be covered by insurance, but will have to be paid by you personally.
- **There is a $40 charge for no-show ($25 if your insurance is AHCCCS, per ARS 36-2930.01)**
- These fees must be paid prior to beginning the next treatment session.

Initial: _____

APPOINTMENT SCHEDULING

Please make every attempt to be on time for your appointments. If you arrive less than 10 minutes late we will likely accommodate you but call to verify this. If you are running more than 10 minutes late we will likely reschedule your appointment to a different time but call us to see whether or not we can accommodate you. If you are ever waiting in the lobby for more than 10 minutes, please let the front desk staff know so that we can let the therapist know as soon as possible.

Please read and sign below:

- I hereby authorize BODYCENTRAL Physical Therapy to release my records to my referring physician, my primary care physician, and my insurance carrier to obtain payment for services that shall be rendered.

Signature_____ Date_____

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- I hereby authorize payment directly to the business office of BODYCENTRAL Physical Therapy, if any, otherwise payable to me for services.
- Co-payments/Coinsurance/Deductible payments are due at the time of services rendered.
- I understand that I am responsible for the charges not covered by insurance and for any missed appointments that are not cancelled 24 hours prior to the appointment. To the extent permitted by Arizona statue, I agree, in the event of nonpayment to assume the costs of interest, collection, and legal action.
- I hereby authorize my insurance carrier to release information regarding my coverage to BODYCENTRAL Physical Therapy. I authorize agents of any hospital, treatment center, or previous physician to furnish copies of any records of my medical history, services, or treatment.
- I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services given by BODYCENTRAL Physical Therapy. In the event my insurance carrier does not accept assignment of benefits, or if payments are made directly to my representative, or me I will endorse such payments to BODYCENTRAL Physical Therapy.
- This agreement/consent will remain in effect unless revoked by me in writing, signed by myself and by an authorized representative from BODYCENTRAL Physical Therapy.

NON-PAYMENT ON ACCOUNT

Should collection proceedings or other legal action become necessary to collect to an overdue account, the patient or the patient's Responsible Party understands that BCPT has the right to disclose to an outside agency all relevant personal and account information necessary to disclose to collect payment for services rendered. The patient, or the patient's Responsible Party, understands that they are responsible for all costs of collection including, but not limited to, interest, all court costs, Attorney fees, and all collection fees.

Signature_____ Date_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE REVIEW IT CAREFULLY.

HOW WILL WE USE AND DISCLOSE YOUR INFORMATION?

Treatment. Your health information may be used by BODYCENTRAL staff members or disclosed to other health care providers for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, after an evaluation with your physical therapist, the therapist may send a copy of that evaluation to your referring physician. That information may also be disclosed to people that assist with your care, a spouse, or legal guardian.

Payment. Your health information may be used to obtain payment for the medical services provided to you. For example, your health plan may request to see parts of your record before they will pay us for your treatment.

Health Care Operations. Your health information may be used as necessary to conduct day to day operations regarding budget planning and management activities. For example, your health information may be used to perform quality assurance activities at BODYCENTRAL Physical Therapy, or to develop marketing strategies for the practice. This information may be disclosed to any of the provider networks in which we participate for quality assurance and billing purposes as well.

Law Enforcement/Government Audits. Your health information may be disclosed to law enforcement agencies to support government audits and inspections and to facilitate law enforcement investigations. For example, if the Federal Government (Medicare) requests information, your information may be disclosed at that time.

Appointment Reminders. We may want to call you by phone at your home or office to remind you of appointments with us. If you do not wish us to leave a message with someone at your home, on your answering machine, or with a co-worker at your place of employment, please advise us of this.

Other Uses. Any other use or disclosure of your health information requires your written authorization.

WHAT ARE YOUR INDIVIDUAL RIGHTS?

You have certain rights under the federal privacy standards. These include:

Communications. You can request that our practice communicate with you about your health and related issues in a particular manner, or at a certain location. For example, you may ask that we talk to you while you are at home rather than when you are at work. We will accommodate reasonable requests.

You can request a restriction in our use or disclosure of your health information for treatment, payment or health care operations. You also have the right to restrict disclosure of your health information to only certain individuals involved in your care or payment of your care, such as family members or friends. We are not required to agree to your request, however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you.

You have a right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to BODYCENTRAL Physical Therapy, P.C..

You may ask us to amend your health information if you feel it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be submitted in writing to BODYCENTRAL Physical Therapy, P.C.. You must provide us with a reason that supports your request for amendment.

You have a right to a list of disclosures we make of your medical information subject to federal privacy requirements. However, information released in certain circumstances, such as disclosures for payment, or treatment will not be included in the list.

You have a right to a copy of this notice. You may at any time request a copy of this document from us.

BODYCENTRAL Physical Therapy, P. C. Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We are also required to abide by the policies and procedures outlined in this notice.

RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION

You may generally inspect or copy the protected health information that we maintain. As permitted be federal regulation, we require that request to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting our privacy official- Jennifer Allen. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

COMPLAINTS

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter to:

Jennifer Allen, P.T. Privacy Officer
BODYCENTRAL P.T.
3124 N SWAN ROAD
TUCSON, AZ 85712
(520) 325-4002

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

EFFECTIVE DATE

This notice is effective on or after April 14, 2003