COLLINS
Physical Therapy Institute

Collins Physical Therapy Institute, Inc.

Dear Patient,

We are pleased that you have chosen Collins Physical Therapy Institute for your physical therapy needs.

Please take time to fill these forms out completely **prior** to your scheduled appointment so that the therapist can spend the full appointment with you.

On the day of your appointment, please bring:
- Completed forms
- Insurance card(s)
- Prescription for physical therapy with diagnosis

PLEASE NOTE: If you have an insurance plan that requires a referral/authorization to see a specialist, please contact your primary care physician or medical group to obtain a referral prior to your appointment date.

Please arrive 15-30 minutes early to allow sufficient time for check-in.

Sincerely,

Collins Physical Therapy Institute, Inc.

Please tell us how you found us:
(Please check all that apply)

☐ **My doctor referred me to your clinic**

☐ **I found out about your clinic from a friend**

☐ **I was a previous patient**

☐ **Family member**

☐ **I heard about your services from one of your physical therapists**

☐ **I learned of your clinic from my Insurance Company**

☐ **I learned of your clinic and services from the internet**

☐ **Other** _____

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Name: _____ **SSN:**_____ **Date:**_____

Leisure activities, including exercise routines:_____
Occupation, including activities that comprise your workday:_____

Age: **Height:** **Weight:**
Are you on a work restriction from your doctor? Yes No **Are you latex sensitive? Yes No**
Do you smoke? Yes No **Do you have a pacemaker? Yes No**
FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No
ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following (check all that apply)?

_fatigue
_fever/chills/sweats
_nausea/vomiting
_weight loss/gain
_difficulty maintaining balance while walking
_falls
__numbness or tingling
_muscle weakness
_dizziness/lightheadedness
_heartburn/indigestion
_difficulty swallowing
_changes in bowel or bladder function
__constipation
__diarrhea
__shortness of breath
__fainting
_cough
__headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

__cancer
__heart problems
_chest pain/angina
__high blood pressure
_circulation problems
_blood clots
_stroke
_anemia
_bone or joint infection
_chemical dependency (i.e., alcoholism)
_depression
__lung problems
_tuberculosis
_asthma
_rheumatoid arthritis
_other arthritic condition
_bladder/urinary tract infection
_kidney problem/infection
_sexually transmitted disease/HIV
_pelvic inflammatory disease
_thyroid problems
_diabetes
_osteoporosis
__multiple sclerosis
_epilepsy
_eye problem/infection
_ulcers
__liver problems
__hepatitis
__pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

__cancer
__heart problems
__high blood pressure
__diabetes
__stroke
_depression
_tuberculosis
__thyroid problems
__blood clots

During the past month have you been feeling down, depressed or hopeless? **YES NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**
Is this something with which you would like help? **YES YES, BUT NOT TODAY NO**
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. _____ 2._____ 3._____

4. _____ 5. _____ 6._____

Have you ever taken steroid medications for any medical conditions? **YES NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2._____ 3._____

What date (roughly) did your present symptoms start?_____

What do you think caused your symptoms? _____

My symptoms are currently: _Getting Better __Getting Worse __Staying about the same

I should not do physical activities that might make my pain worse:___Disagree___Unsure___Agree

Treatment received so far for this problem (chiropractic, injections, etc) _____

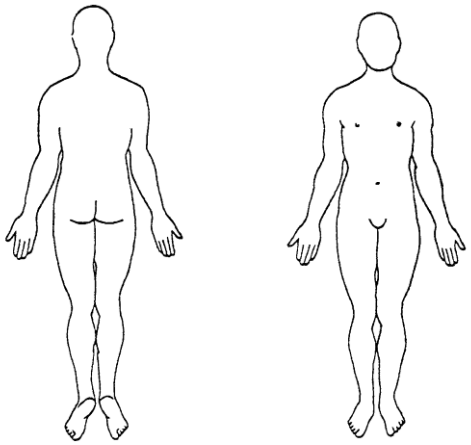
Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

Have you ever had this problem before: ___Yes___No When_____Treatment rec'd_____

How long did it take for you to feel better? _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right :



My symptoms currently: _Come and go ___Are Constant _Are constant, but change with activity

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Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. _____
2. _____
3. _____

How are you currently able to sleep at night due to your symptoms?

__No problem sleeping _Difficulty falling asleep __Awakened by pain _Sleep only with medication

When are your symptoms worst? _Morning ___Afternoon ___Night __After exercise
When are your symptoms the best? ___Morning ___Afternoon ___Night __After exercise

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Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

Your current level of pain while completing this survey:_____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____

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Consent to Treat

I do hereby consent to such treatment by the authorized licensed personnel of Collins Physical Therapy Institute as may be dictated by prudent medical practice by my illness, injury or condition.

Thank you for allowing us the opportunity to serve you. If you have any questions about the above information or any uncertainty regarding your insurance coverage, please ask for assistance. Kindly sign and date this form to indicate that you understand and agree to the terms of this payment/consent to treat.

Please be advised that we are not a credit guarantor. Therefore, failure to maintain these arrangements may result in the placement of your account with an outside collection agency or attorney for collections. You will remain financially responsible for services rendered, regardless of the payment option selected above. In the event your account becomes delinquent and is therefore default of payment, the patient, legal guardian, or admitting parent will be responsible for the principle amount owed and all reasonable costs associated with the recovery of this debt.

_____ _____

Sign Name Date

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COLLINS PHYSICAL THERAPY
INSTITUTE, INC.
Office Payment Policy

It is the policy of Collins Physical Therapy Institute that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their deductible, co-pay and/or co-insurance payment at the beginning of each visit. At the conclusion of your therapy with Collins Physical Therapy, you may be billed for any outstanding balances.

If you are covered by health insurance with physical therapy benefits, we will be happy to bill your insurance. Please provide your insurance information to the office staff and we will verify your coverage as a courtesy. Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by a physician does not necessarily guarantee that your insurance will cover our services. **Please remember that you are 100% responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.** Therefore, we highly recommend you also contact your insurance carrier and check into your coverage for physical therapy. Do not assume that you will not owe anything if you have more than one insurance policy. If you need special arrangements to be made, please discuss this with the practice manager before starting your treatments.

Please initial your payment method and sign below that you have read, understand, and agree with all of the information on this page:

_____1. **PRIVATE HEALTH INSURANCE (PPO):** Some insurance plans require authorization or a referral from your primary physician. Most insurance plans have a patient responsibility (deductible or amount paid by the patient before the insurance policy begins payment for services) and/or a co-pay (set dollar amount per visit) or coinsurance (a percent of the allowed charges). **Deductibles, copay, and coinsurances, are due at the time of service.** Should your insurance deny coverage, we will bill you for the outstanding amount.

_____2. **HMO Insurance:** Authorization from your insurance must be obtained prior to treatment. Any copay or coinsurance is due at the time of treatment. If your HMO plan also has a Point of Service option you are using, please be sure you understand the difference in your Point of Service coverage verses your HMO coverage.

_____3. **MEDICARE:** Collins Physical Therapy Institute, Inc. is a certified Medicare provider. Some secondary insurance plans cover the portion due and services after Medicare benefits are exhausted, but not always. All Medicare covered patients are subject to an annual deductible and a cap to physical therapy benefits.

_____4. Secondary Medicare Insurance Provider: _____

_____ 5. **NO INSURANCE (CASH):** If you do not have insurance you may be eligible for an administrative discount if payment is received at time of service. Please notify the office staff that you do not have insurance so that a payment plan can be discussed.

_____6. **WORKER'S COMPENSATION CLAIMS:** Authorization from your insurance adjuster is required before you can begin treatment. Please provide the office with the name and phone number of your adjuster, the date of your injury and your claim number, and any other pertinent information.

I **have reviewed this office payment policy and discussed it with the office. All my questions have been answered to my satisfaction and I understand all the information that has been explained to me:

Patient Signature:	Guardian's Signature: (If patient is <18 years old)	Date:

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Payment Policy

Welcome to Collins Physical Therapy Institute! We are happy to further extend your services by filing your primary and/or secondary insurance for you. Please be sure to read all of the following information carefully:

- According to _____(insurance carrier) you have satisfied $_____of your $_____ (yearly) deductible. The balance of $_____is payable at the time of service (as based upon your insurance's fee schedule).
- A co-payment of $_____and/or_____% is due at each visit.
- Worker's Compensation: We will bill your worker's compensation carrier for all charges.
- Self-Pay: Balance is due in full at the time services are rendered.
- Motor Vehicle you are responsible for _____%

Cancellation Policy

It is our policy to charge a $25 fee for Cancellation or No Show to your appointment. If for any reason you cannot keep your appointment, please call 24 hours prior to your appointment to cancel. This is not covered by your insurance and you will be responsible.

Please Note: It is our policy that the patient will be discharged from our services after three cancellations or no-shows for his/her appointments.

_____ _____

Sign Name Date

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ACKNOWLEDGEMENT OF PATIENT INFORMATION PRACTICES

I have read and fully understand Collins Physical Therapy Institute's Notice of Patient Information Practices. I understand that Collins Physical Therapy Institute may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Collins Physical Therapy Institute's Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____Patient Name

_____Signature (Guardian if patient is a minor)

_____Date

Updated 7-2-14

NOTICE OF PATIENT INFORMATION PRACTICES

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

LEGAL DUTY
Collins Physical Therapy Institute is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION
Collins Physical Therapy Institute uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Collins Physical Therapy Institute may also use or disclose your personal health information without prior authorization for emergencies, research studies, auditing purposes, and public health/statistical purposes. We also provide information when required by law. In any other situation, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Because of the close proximity of treatment areas at Collins Physical Therapy Institute, it may be possible for other patients to overhear your treatment plan or other personal information about your condition. Private treatment rooms are available upon request.

Collins Physical Therapy Institute may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS
You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances.

CONCERNS AND COMPLAINTS
If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Practice Manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on our health information practices or if you have a complaint, please contact the following person:

Jackie Augustine, Office Manager
800 Goodlette Road N, Ste 140
Naples, FL 34102
Tel: 239-384-5952 Fax: 239-384-5970

****Please retain this copy for your records****