Elevate Physical Therapy Patient Information

Please present insurance card(s) for copying

Patient Full Name: _____

Date of Birth: _____

Age: _____

SS #: _____

Sex: M/F

Street Address: _____

City, Zip and State: _____

Primary Phone#:_____

Email:_____

*Appointment reminders (please choose one)

☐ Email ☐ Phone Call ☐ Text

Financial Party/Policy Holder/Name on Insurance Card (if different than patient):

Name:_____ Relation_____ Date of Birth: _____

SS #: _____ Street Address (if different):_____

Phone #:_____ City, Zip and State:_____

Emergency Contact:_____ Relation:_____ Phone #:_____

Initial the following statements and sign below:

☐ I authorize Elevate to use health and medical information for treatment, payment and healthcare operations.

☐ I consent to the Elevate Physical Therapy Staff performing procedures as prescribed by my physician and/or services deemed for my benefit.

☐ I have read Elevate's Financial Policy and agree to all terms. I understand that a $20 fee will be billed directly to me for each no-show or cancellation made without 24 hr. notice.

☐ I have read the HIPAA Notice of Privacy Practices.

☐ I understand that Elevate may verify my insurance benefits as a courtesy to me, but it is my own responsibility to know and verify my benefits with my insurance company. Elevate is not responsible for misquoted benefits by my insurance.

☐ I consent to students being involved in my treatment with direct supervision provided by a Physical Therapist or Physical Therapist Assistant.

☐ I consent to my home exercises from Web Exercises being sent to my email that I listed above.

☐ I consent to Elevate using pictures/videos of me for marketing/educational purposes.

Signature (parent or guardian required if patient is minor): _____ Date:_____

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Other Information:

Is condition related to motor vehicle accident: Y/N Date of onset/accident: _____

Is condition an employment related injury: Y/N Date of onset/accident: _____

Who is your primary care doctor? _____

Patient Medical History Form-For Clinic Use ONLY

Please mark all that apply:

- ☐ Alzheimer's
- ☐ Cardiovascular Disease
- ☐ Cauda Equina Syndrome
- ☐ Cerebral Vascular Accident
- ☐ Current Infection
- ☐ Diabetes Mellitus Type 1
- ☐ Diabetes Mellitus Type 2
- ☐ Fibromyalgia
- ☐ Fracture or Suspected Fracture
- ☐ High Blood Pressure
- ☐ History of Cancer
- ☐ Huntington's
- ☐ Immunosuppression
- ☐ Lupus
- ☐ Muscular Dystrophy
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Parkinson's
- ☐ Rheumatoid Arthritis
- ☐ Traumatic Brain Injury

Others:_____

Please list all medications including frequency and dosage:

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____

Please list all surgeries/hospitalizations and dates:

1._____
2._____
3._____
4._____
5._____
6._____
7._____
8._____
9._____

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Current conditions:

Brief description of condition: _____ Date of onset/accident: _____

Pain:
Pain Scale 0-10 0= No pain 5= Moderate pain 10= Extreme pain
At Your Best_____ Average_____ At Your Worst_____ Location of pain:_____

Previous history of similar symptoms?	Y/N	Smoking?	Y/N
Recent, unplanned weight loss?	Y/N	Are you currently pregnant?	Y/N
Unexplained night pain?	Y/N	Do you have a pacemaker?	Y/N
Fevers or night sweats?	Y/N	Are you latex sensitive?	Y/N
Nausea/Vomiting?	Y/N	Ice sensitive?	Y/N
Unexplained weakness or fatigue?	Y/N	Heat sensitive?	Y/N

Have you had previous experience with physical therapy? Y/N

How many falls have you had in the last year?_____

I affirm that the above information is accurate and true.
Signature (parent or guardian required if patient is minor): _____ Date:_____

Who may we thank for referring you to us?

☐ Physician: _____

☐ Patient/Client: _____

☐ Online: _____

☐ Other: _____

Elevate Physical Therapy FINANCIAL POLICY

To provide the best possible care and most effective treatments, this is the financial policy of Elevate Fitness and Rehab. This is an agreement between Elevate Physical Therapy (EPT) and the Patient/Responsible Party signed on this form. **By executing this agreement, you are responsible for all medical bills and other charges that result from services rendered by EPT.**

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the provider and is not a substitute for payment. Regardless of insurance coverage you are responsible for all balances incurred. Some insurance companies may pay fixed allowances for certain procedures, sometimes referring to these as "Reasonable and Customary Fees." We do not accept this as payment in full, unless otherwise restricted by law or contract agreement we may have with your insurance carrier(s). Many insurance companies pay only a percentage of the charge, leaving it your responsibility to pay any deductible amount, co-insurance amount, co-pays (due at each visit) and any other balance not covered by your insurance carrier(s). As a courtesy, our office may inform you of the benefits we were quoted by your insurance carrier(s). However, this is not a guarantee of your actual benefit plan or payment. If you have any further questions, please contact your insurance carrier(s).

ASSIGNMENT OF BENEFITS: I hereby assign all medical/physical-occupational therapy benefits, to which I am entitled, Medicare, private insurance and other health plans to: Elevate Sports Medicine, EPT. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize EPT to release all information necessary to secure the payment, via fax transmittal or hard copy. Medical records will be accessible to all physical therapists of EPT.

INJURIES AT WORK: In the event it is determined by your industrial/Workman's Compensation insurance that the illness/injury is not a result of a compensated Workman's Compensation case, you will be responsible to pay usual and customary fees for services rendered. If you do not have your information at this time, please get it to us within 48 hours.

AUTO ACCIDENTS: Auto insurance claims will be billed to YOUR auto carrier, not to any other parties' auto carrier due to Utah's No-Fault Law. If your auto PIP exhausts, which in many cases is true, as you may have already been to the emergency room, had surgery, etc, we will bill your health insurance that you have provided. If you wish to not have your health insurance billed, you will be responsible for all charges. If you do not have your information at this time, please get it to us within 24 hours.

PERSONAL INJURY: If you are dealing with a lawsuit or claim, we require verification from your attorney, as well as a lien agreement that we may keep on file and a monthly payment plan. Please remember even if you have an attorney you are ultimately responsible for your bill and need to update our office on the status of your case frequently.

PAST DUE ACCOUNTS: I agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. I agree that interest will accrue on all past-due amounts at the rate of 18% per annum (1.5% per month) until paid in full. In the event any amount(s) is/are referred to a third-party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 40% of the principal amount(s) owing as allowed by Utah Code Annotated, sec.12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today. I hereby consent to being contacted by telephone at any telephone number (including but not limited to wireless/cellular phone numbers) provided by me or anyone associated with me or acting on my behalf to EPT or anyone acting on its behalf. I understand and agree that such calls may be initiated by EPT or any of its affiliates, agents, contractors or assigns, including but not limited to billing companies and/or third-party collection agency(ies), and that the methods of contact may include using pre-recorded/artificial voice messages and/or the use of an automated dialing device and/or the use of text messages—some or all of which may result in data charges. I also consent to receiving e-mails at any e-mail address provided by me or anyone associated with me or acting on my behalf.

RETURNED CHECKS: There is a fee (currently $20) for any checks returned by the bank.

MISSED APPOINTMENT FEE: The second time a patient does not show up on time for an appointment or cancels with less than 24 hours notice, a $20 fee will be charged. This fee must be paid before a new appointment is scheduled.

SELF PAY ACCOUNTS: If you do not have health insurance, we do offer self pay plans. Self Pay payments are due at the time of service. Please speak to our Clinical Director for more information. If you are unable to provide us with your health insurance, worker's compensation insurance or personal injury insurance within 48 hours of your first visit you may be turned over to a self pay account status. Even if you provide us with your insurance information after the initial 48-hour period we reserve the right to refuse to bill your insurance.

MONTHLY STATEMENT: If you have a balance on your account, we will send you a monthly statement. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable on or before the due date specified on the statement and is past due if not paid on or before that date. We do charge interest (2%) on all past due accounts; interest will begin accruing once the account becomes 90 days past due.

HIPAA Notice of Privacy Practices

Elevate Physical Therapy & Sports Medicine
147 W. 400 N. Orem, UT 84057
(801) 221-9060

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law it also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of **Protected Health Information.**
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to your, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected heath information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical student, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situation include: as Required By Law, Public health issues as required by law, Communicable Diseases: Health Oversight Abuse or neglect; Food and Drug Administration requirements: Legal Proceeding: Law enforcement: Coroners, Funeral directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when requirements of section 164.500.

Other Permitted and Required Uses and Disclosures Will be made only with your consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization at any time, except to the extent that your physician or the physician's practice has

taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit, to use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the secretary of Health and Human Services if you believe your primary rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Elevate Physical Therapy and Sports Medicine will send your progress reports to your physician through email.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name_____Signature_____Date