PATIENT INFORMATION

Name: _____ DOB: _____ Age: ___

Address: _____Sex:_____

City: _____ State: _____ Zip: _____

Email address: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Responsible Party (if different from above)

Name: _____ DOB: _____

Address: _____ E-mail: _____

City: _____ State: _____ Zip: _____

Email address: _____ Cell Phone: _____

Home Phone: _____ Work Phone: _____

Referring Physician

Name: _____Phone:_____ Date of Last Visit: _____

City/State: _____ Date of Surgery: _____

Employer Information

Name: _____ Address: _____

Phone: _____ Occupation: _____

Hours worked per week: _____ Activities during work (sitting, walking, etc.): _____

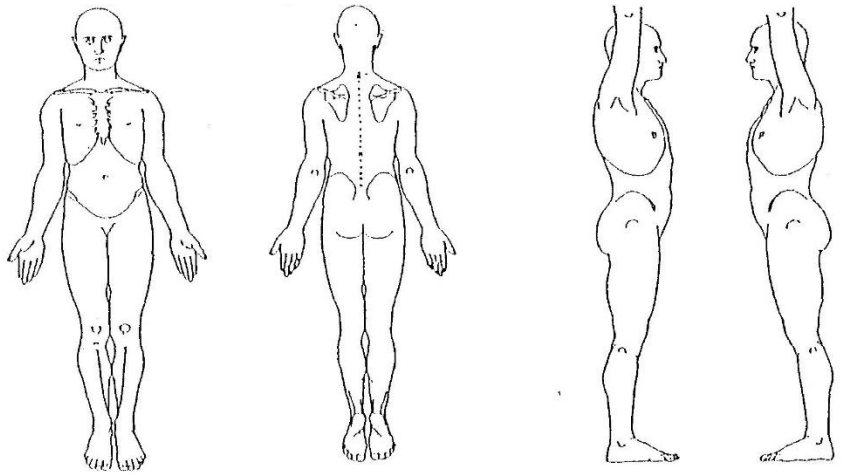
Emergency Contact

Name: _____ Relationship: _____ Phone: _____

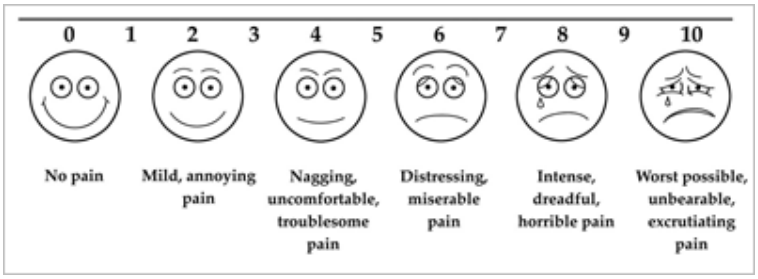
How did you hear about us?_____

2015-B Woodbrook Court
Charlottesville, VA 22901
434.282.5361/highgearpt.com
updated 7/24/19

Current Medical History:
Pain related to current injury



Use X marks to show where you feel pain, numbness, tingling. Circle the level of pain on the scale below and describe your pain (i.e. sharp, dull, achy, burning, deep, radiating, etc.)



Chief complaint (why patient is seeking physical therapy care): _____

Date of injury: _____

What do you think caused your pain? Why? _____

Since its initiation, has the pain changed? (worse, better or same) _____

Is there anything that increases your pain? _____

What eases your symptoms? _____

Are you taking any medications, vitamins and supplements? ( ) Yes ( ) No If yes, list below with dosage

_____

What are your goals for physical therapy? _____

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PAST MEDICAL HISTORY

Have you ever had any of the following? If yes, please briefly note date and specifics:

1. Surgeries? ( )Yes ( ) No _____
2. Have you fallen in the past year and if so how many time? _____ Why did you fall? _____
3. Are you pregnant? (weeks) ( ) Yes ( ) No _____
4. Females do you have an IUD? ( ) Yes ( ) No
5. Other problems that have been diagnosed by a physician? ( )Yes ( )No

   _____

6. Are you currently under the care of a doctor of medicine, osteopathy, chiropractic, podiatry, dental surgery, licensed nurse practitioner, or licensed physicians assistant for the symptoms you are seeking physical therapy?
   ( ) Yes ( ) No If yes, name of practitioner you are seeing: _____

REVIEW OF SYSTEMS

Please mark the appropriate 'NO' lines, or provide details

NO		DETAILS
___	General (i.e. fever or chills, poor general health, unexplained weight loss, fatigue, unexplained sweating)	_____
___	Skin (i.e. rashes, new skin lesions, or a change in moles)	_____
___	Eyes (i.e. blurred vision, or change in visual acuity)	_____
___	Ears (i.e. ear pain, or difficulty hearing)	_____
___	Nose (i.e. nasal congestion, discharge, or bleeding)	_____
___	Mouth/Throat (i.e. sore throat or difficulty swallowing)	_____
___	Respiratory (i.e. shortness of breath, cough, wheezing)	_____
___	Cardiovascular (i.e. high/low blood pressure, palpitations)	_____
___	Gastrointestinal (i.e. nausea, vomiting, diarrhea, constipation, abdominal pain, discolored stools)_____	
___	Genitourinary (i.e. problems initiating or controlling my bladder, or have problems with urinary frequency)	_____
___	Endocrine (i.e. diabetes, excessive thirst, glandular issues)	_____
___	Blood disorders (i.e. bruise easily, bleeding)	_____

NO

___ Psychiatric (i.e. depression, anxiety, suicidal thoughts or attempts) _____

___ Cancer _____

___ Past Orthopedic Injuries (i.e. sprains fractures etc.) _____

All information listed above is accurate as of today's date and I agree to notify High Gear Physical Therapy, LLC of any changes in my medical status while under their care.

_____ _____ _____

Patient/Guardian Printed Name Signature Date

Payment Agreement, Patient Policies, Consent for Assessment and Treatment

Thank you for choosing High Gear Physical Therapy, LLC as your physical therapy provider. Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

- You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.
- Payment is expected at time of service unless you have made other payment arrangements with us.
- **Out-of-Network Policy.** (Commercial Health Plans - Does not apply to Medicare) If we are out-of-network with your health plan and you have out-of-network benefits, we will electronically submit your claims to your insurance as a courtesy or we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. You are responsible for contacting your insurance company to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.
- **Medicare Policy (for Medicare Part B).** If you are a Medicare beneficiary, you understand that our licensed physical therapists are ***not*** enrolled as Medicare providers. Medicare has onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide. Since we are not enrolled providers, we cannot submit claims to Medicare ***and*** Medicare will not pay for our services even though the same services might be paid by Medicare if you obtained them from a Medicare enrolled provider. Therefore, by choosing our services, you are exercising your right to privacy and electing, of your own free will, not to use your Medicare benefits. As such, you are agreeing to pay cash at the time of service for all services you elect to receive from us with no expectation that Medicare will reimburse you. You understand that we will not submit claims to Medicare on your behalf or provide you with a statement or billing codes that you can submit to Medicare yourself. If you want Medicare to pay for services that might be considered covered benefits, you should seek those services from a Medicare enrolled provider. If you decide at any point after you start services with us that you want Medicare to pay for the services it covers, we will be happy to recommend a Medicare enrolled provider and terminate your services with us. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare for reimbursement or to obtain a denial for a Medicare supplemental insurance plan.
    - **Medicare supplemental insurance plans.** If your Medicare supplemental insurance plan will reimburse you for medically necessary services by providers not enrolled with Medicare, we will provide you with a letter stating we are not enrolled as a Medicare provider and a statement that you can submit to your supplemental plan. However, you should be prepared that your supplemental plan may not pay for services by providers not enrolled with Medicare. If your supplemental plan requires you to obtain a denial from Medicare before it will pay for your services, we cannot submit a bill to Medicare merely to get a denial because we are not enrolled providers.
    - **Medicare Advantage Plans and Medicare Replacement Plans.** We are not in-network with any Medicare Advantage or Replacement Plans. If your Medicare Advantage or Replacement Plan offers out-of-network benefits for services received from providers not enrolled with Medicare and we don't have to directly submit your claims, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. However, you should be prepared that your health plan may not pay for services by providers not enrolled with Medicare. You are responsible for contacting your health plan to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.
    - **Medicare as a Secondary Payer.** If you have a commercial insurance plan, we will provide you with a copy of your bill that you can, at your discretion, submit to your commercial health plan for reimbursement for the services your health plan covers. However, since we are not Medicare enrolled providers, Medicare will not pay your copays, co-insurance or deductibles as a secondary payer. You understand and agree to carry out whatever procedures are necessary to prevent your commercial insurer from automatically forwarding our bills to Medicare.

- **Cancellation Policy.** A $100 fee will be charged to the patient for all visits for which the patient no-shows or cancels without 24 hours' notice.
- **Wellness & Fitness Services.** Most commercial health plans and Medicare do not cover the wellness or fitness services we offer. Therefore, we will provide you with a receipt for these services upon request.
- **Privacy Rights.** You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. If you pay for your services at the time of service, we assume you are exercising this right to privacy we will not disclose your medical records to any third party, including your health insurance carrier or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Authorization to Release Protected Health Information form before we will disclose your health information.
- **Appeals Policy.** You understand that you are responsible for filing all appeals of adverse benefit determinations. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.
- If my account is sent to an outside collections agency, I will be responsible for all fees associated with collecting my account plus a $200 administrative fee payable to High Gear Physical Therapy, LLC.

- I authorize High Gear Physical Therapy, LLC to release information regarding my medical history, treatment, examination results, progress and diagnosis to my physician, other health care providers involved in my care.
- I hereby authorize High Gear Physical Therapy, LLC through its appropriate personnel, to perform, or have performed upon me, or the above named patient, such assessment and treatment procedures as are deemed necessary.
- No guarantees have been made to me about the outcome of my physical therapy care.
- I understand that there are inherent risks involved when performing physical therapy and exercise although these risks have been shown to be minimal.
- I acknowledge that I have received and/or read a copy of the Notice of Privacy Practices for High Gear Physical Therapy, LLC available at highgearpt.com and I consent to the use of my personal health information for the purpose of treatment, payment and health care operations.

I HAVE READ, UNDERSTAND AND AGREE TO THESE PAYMENT TERMS. I acknowledge that I have chosen, of my own free will, to obtain the services provided by High Gear Physical Therapy, LLC and have agreed to pay out of pocket for my services without any expectation that my health plan will reimburse me. If I am a Medicare beneficiary, I attest that I have chosen not to use my Medicare benefits for the services I am purchasing and am restricting High Gear Physical Therapy, LLC and my therapist from submitting any claims to Medicare pursuant to my right to privacy under HIPAA.

X _____ Date: _____
Signature of Patient and/or Guardian

X_____ Date: _____
Signature of Provider Representative
A photocopy of this agreement is to be considered valid, the same as if it was the original.

Consent for Communication

Patients/Clients frequently request that we communicate with them by phone, voicemail, email or text. High Gear Physical Therapy, LLC respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur. Since email and texting can be inherently insecure as a method of communication, we will only communicate with you by email or text with your written consent at the email address or phone number you provide to us below. Please be aware that if you have an email account through your employer, your employer may have access to your email.

When you consent to communicating with us by email or text you are consenting to email and texting communications that may not be encrypted. As well voicemail or answering machine messages may be intercepted by others. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through phone, voicemail, email or text. High Gear Physical Therapy, LLC will not be responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you have consented to.

You may choose to limit the type of voicemail, email or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text.

- ☐ I do not consent to any voicemail, email or texting communication.
- ☐ I consent to receiving communication about the scheduling of appointments or other communications that do not reveal my protected health information only by the following means (check all that you consent to):
  - Email
  - Text
  - Voicemail
- ☐ I consent to all communication, including but not limited to communication about my medical condition and advice from my health care providers by the following means (check all that you consent to):
  - Email
  - Text
  - Voicemail

E-mail address you are consenting to communicate through: _____

Phone number you are consenting to communicate through:_____

Patient Signature: _____ Date_____

Authorized Representative/Guardian Signature:_____ Date_____

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