



2780 28th Avenue
Greeley, CO 80634
970.339.2444

Patient Information and Billing Authorization

SECTION ONE

Patient First Name: _____ Middle Initial: _____ Last Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Gender: M F Social Security # _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Preferred Method of Contact: Home Phone Cell Phone Email _____

SECTION TWO

Insurance Information

Primary Insurance: _____ Member ID: _____ Group #: _____

Secondary Insurance: _____ Member ID: _____ Group #: _____

Guarantor's First Name: _____ Last Name: _____

Guarantor's Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Relationship to Patient: _____

SECTION THREE

Please provide an Emergency Contact:

Name: _____ Relationship: _____ Phone: _____

PHYSICAL THERAPY NEW PATIENT PAPERWORK

ADEO PHYSICAL THERAPY BILLING POLICY AND BILLING AUTHORIZATION

As a courtesy, Adeo Physical Therapy will obtain benefits from your insurance company. Benefits quoted by your insurance company are not a guarantee of payment. Payment will be considered at the time a claim is received by your insurance company.

The patient/parent/responsible party will be responsible for verifying therapy benefits with your insurance.

Although Adeo Physical Therapy will attempt to obtain payment from third party payers, it is understood that any amount not paid by the health care plan, insurance or other third-party payer of the patient will remain the responsibility of the undersigned.

Adeo Physical Therapy will charge interest on all patient responsibility balances 30 days after the original statement date. If payment is not received from the patient/parent/responsible party within the 30 days as stated, interest will accrue at 1.5% per month (18% per year) and charged to the patient's account.

PRIVATE PAY PATIENTS: Adeo Physical Therapy WILL NOT FILE OR BILL patient's insurance company after they have agreed to the Private Pay/Self Pay terms. Payments **MUST** be received at time of service.

- **CO-PAY:** Co-pay is due at the time of service.

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and any other health plan to Adeo Physical Therapy. This assignment will remain in effect until revoked by me in writing.

I hereby agree to pay any and all charges that are not covered by insurance. I hereby authorize Adeo Physical Therapy to release all information to secure payment. To ensure continuity of care, I hereby authorize the release of all medical records to my primary and referring physicians. I authorize Medicare, Medicaid, private insurance and any other health plan to furnish Adeo Physical Therapy any information regarding payment of my claim.

Patient's Acknowledgement Signature

Date

PARTICIPANT RELEASE

I understand that there are risks, both foreseeable and unpredictable, associated with Physical Therapy and the use of the Pool. I am aware of the risks and agree that my participation is at my own risk. I hereby release Adeo Physical Therapy, its employees and agents from any and all liability connected to my participation in the programs at Adeo Physical Therapy. I furthermore consent to therapy treatments at Adeo Physical Therapy.

****PLEASE INITIAL THAT YOU HAVE READ AND UNDERSTAND THE ABOVE PARAGRAPH**

PATIENT CANCELLATION & NO-SHOW POLICY

It is the patient's responsibility to give Adeo Physical Therapy 24 hours notice if they will be unable to attend an appointment. Patients who fail to give 24 hours notice will be charged as stated below:

\$50.00 No Show/Same-Day Cancellation Fee

This fee will be charged to YOU and not your Insurance Company.

This is a Strictly Enforced Policy

- If you are more than 10 minutes late for your appointment, you may not be treated, and it may be considered a same-day cancellation.
- Your therapist reserves the right to discontinue your therapy if you show a pattern of irregular appointment attendance.
- Two consecutive unattended/NO-SHOW appointments will result in waitlist only status (you will not be allowed to book an appointment), and in some cases, discharge from therapy. Should the latter occur, your referring physician will be notified of your discharge. You will be billed the cancellation/NO-SHOW FEE.

Patient's Acknowledgement Signature

Date

HIPAA ACKNOWLEDGEMENT/CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information for the purposes of:

- Providing treatment, including direct or indirect treatment by other health care providers involved in my treatment
- Obtaining payment from third-party payers (e.g., my insurance company)
- Facilitating the day-to-day health care operations of our practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

_____ I do wish to receive a copy of Adeo Physical Therapy's Notice of Privacy Practices

_____ I do not wish to receive a copy of Adeo Physical Therapy's Notice of Privacy Practices

I understand a copy of the HIPAA Acknowledgement and Consent Form is available from Adeo Physical Therapy from:

- www.adeocoPT.org
- Front Desk Receptionist
- Adeo Physical Therapy Lobby

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with said restrictions. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient's Acknowledgement Signature

Date

PHYSICAL THERAPY NEW PATIENT PAPERWORK

Authorization for Release of Information to Family Members or Friends

Patient name: _____ Date of Birth: _____

This form is used to release your protected health information. Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient’s consent. If you wish to have your medical or billing information released to family members, you must sign this form. Signing this form will allow us to give information only to the individuals indicated below.

I authorize *Adeo Physical Therapy* to release or discuss my medical and/or billing information to the following individual(s):

- 1. _____ Relationship to patient: _____
- 2. _____ Relationship to patient: _____
- 3. _____ Relationship to patient: _____

In the event we are unable to reach you, you may authorize us to leave a voicemail regarding your care or billing information on the phone number provided to us by you as your primary point of contact.

I, _____ (name),

DO DO NOT authorize Adeo Physical Therapy to leave appointment information on a **voicemail**.

DO DO NOT authorize the release of medical and/or billing information on a **voicemail** if Adeo Physical Therapy is unable to reach me.

FOR YOUR INFORMATION:

I understand I have the right to revoke this authorization at any time, and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to the individuals listed above is no longer protected by federal or state law and may be subject to disclosure by the recipient.

You have the right to revoke this consent in writing.

Patient’s Acknowledgement Signature

Date

POOL THERAPY RULES

During the course of therapy, you may have appointments in our Warm Water Pool.

Pool therapy patients MUST follow these instructions:

1. Sign in at our lobby reception desk and let the receptionist know you have pool therapy today.
2. Once you have been checked in, proceed through the pool doors and sign in again at the pool desk to the left.
3. You may then get changed for your pool therapy session.
4. **DO NOT GET INTO THE POOL UNTIL YOUR THERAPIST ARRIVES.**
5. Once your pool therapy session is over, you must exit the pool immediately.

If you borrow a lock from the pool desk, please return it before you leave.

We look forward to working with you and assisting with your therapy needs!

Patient's Acknowledgement Signature

Date

PHYSICAL THERAPY NEW PATIENT PAPERWORK

ADEO PHYSICAL THERAPY

FILL OUT ALL PAGES COMPLETELY

HISTORY INFORMATION SHEET

PATIENT NAME: _____ TODAY'S DATE: _____

EMERGENCY CONTACT: _____ PHONE _____

The following information is needed in order for your treating therapist to understand why you are here and how they can best help you. Please answer all questions to the best of your ability.

MEDICAL HISTORY

List Surgeries/Hospital Admissions and Dates: _____

List Medical Allergies: _____

List Current Medications: _____

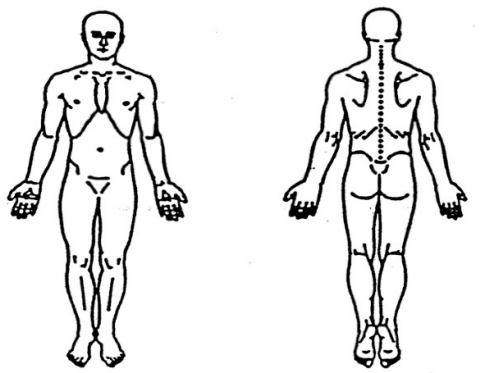
Check the following conditions that apply to you:

- | | | | | |
|--|---|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Fractures | <input type="checkbox"/> Vision Problems |
| <input type="checkbox"/> COPD/Respiratory | <input type="checkbox"/> Vascular Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Back/Neck Injury | <input type="checkbox"/> Meniere's |
| <input type="checkbox"/> CHF/MI/Heart | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fusion | <input type="checkbox"/> Dizziness/Vertigo |
| <input type="checkbox"/> CVA/TIA/Stroke | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Jt. Replacement | <input type="checkbox"/> Headaches | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> MS/Parkinson's | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Depression |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Seizures | <input type="checkbox"/> Panic Attacks |

Other: _____

PAIN DIAGRAM

Please complete the diagram by hand after printing the entire form.



Height _____ Weight _____

PHYSICAL THERAPY NEW PATIENT PAPERWORK

SYMPTOM HISTORY

When did your problem start? _____ Cause of pain: ___Auto ___Work ___Sports
___Daily Life ___Surgery

Pain Scale: 0 = no pain and 10 = emergency pain 0-----5-----10

Pain at rest: _____

Pain w/daily tasks: _____

Average Pain: _____

Since the onset of your symptoms, are the symptoms: ___improving ___worsening
___not changing ___fluctuating ___come and go

What diagnostic tests have you had? ___X-rays ___CT Scan ___Bone Scan ___MRI

___Arthrogram ___Discogram ___Other _____

Results: _____

Have you previously had therapy for this diagnosis? Y / N

Below is a list of words. Please check the ones that best describe your symptoms.

- | | | | | |
|----------------|-------------|----------------|--------------|----------------------------|
| ___lightheaded | ___sharp | ___hot/burning | ___radiating | ___stiff |
| ___unsteady | ___stabbing | ___cold | ___tingling | ___constant |
| ___nauseous | ___shooting | ___deep | ___numb | ___intermittent |
| ___spells | ___pinching | ___dull | ___heavy | ___ringing in ear/fullness |
| ___dizzy | ___swollen | ___ache | ___pressure | ___disabling |

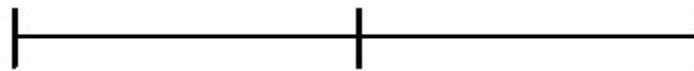
PHYSICAL THERAPY NEW PATIENT PAPERWORK

OPTIMAL INSTRUMENT

Difficulty-Baseline

Instructions: Please check circle the Level of difficulty you have for each activity today.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying Flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving-lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking short distance	1	2	3	4	5	9
10. Walking long distance	1	2	3	4	5	9
11. Walking outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking about all of the activities you would like to do, please mark an "X" at the point on the line that best describes your overall level of difficulty with these activities today. Please complete the diagram by hand after printing the entire form.



I have no difficulty doing any of the activities that I would like to do.

I have extreme difficulty doing any of the activities that I would like to do.

23. From the above list, choose 3 activities you would most like to be able to do without any difficulty (for example: if you would most like to be able to climb stairs, kneel, and hop without any difficulty, you would choose:

1. 12 2. 8 3. 13

1. _____ 2. _____ 3. _____

Patient Signature

Date

Please bring this completed new patient packet to your first appointment. If you have any questions, please call Adeo Physical Therapy at 970.339.0011.