

FOOTHILLS ORTHOPEDIC & SPORT THERAPY, P.C.
Ray Physical Therapy is a division of Foothills

FINANCIAL POLICY

We want to welcome you to **Foothills Orthopedic and Sport Therapy P.C.** We are committed to having your treatment be successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment. No question is too small to ask, whether it is about your treatment, insurance, or financial information. A copy of this is available upon request.

As a service to you we will bill your **primary insurance only** & you will need to give us complete insurance information along with a copy of your card. We no longer bill secondary insurances. **We do require your co-payments be paid at time of service**. Your insurance policy is an agreement between you and your insurance company. We are not a party to that contract. We base our treatment plan on our professional judgment & not on what your insurance company will pay. Therefore all charges are ultimately your responsibility.

Minor Patients

The parent or guardian accompanying a minor is responsible for payment of services. Unaccompanied minors (under 18) will be denied non-emergency treatment, unless the parent or guardian has signed patient information and financial responsibility forms.

Rebill Fee

A Rebill fee of \$10.00 will be charged to your account each time we have to send an additional statement for the patient portion due.

Missed Appointments

Please cancel your appointment at least 24 hours in advance. If repeated cancellations or no shows occur, you will be charged \$25.00 for each missed appointment.

Collections

If your account becomes delinquent, collection proceedings will occur and you will be liable for any collection fees, attorney fees and court costs.

Financial Authorization

I hereby authorize direct payment of medical benefits to **Foothills Orthopedic and Sport Therapy, P.C.** I have read and understand the above financial policy, and I agree to be responsible for any balances not covered by my insurance. My signature below authorizes this office to release medical information to my insurance company only to assist with any outstanding balances on my account.

DATE

PATIENT OR GUARDIAN SIGNATURE

HISTORY & PHYSICAL

Please be accurate and complete as some treatment programs and procedures may be based on this information.

NAME: _____ AGE: _____

OCCUPATION: _____ SPORTS/HOBBIES: _____

FAMILY PHYSICIAN: _____

Send a copy of our Evaluation to him/her? Yes/No

CURRENT MEDICATIONS WITH DOSAGES INCLUDE VITAMINS, OVER-THE-COUNTER, & SUPPLEMENTS: _____

ALLERGIES:(include latex/tape) _____

MEDICAL HISTORY: (Circle any that apply)

Diabetes

Pregnant

Hypertension

Hepatitis

Asthma

Arthritis

Blood Clots

Cancer

Heart Disease

Epilepsy/Seizure Disorder

Multiple Sclerosis

Lupus

Tuberculosis

Pain Stimulators/Pump

Pacemaker

Other _____

LIST RECENT SURGERIES AND ALL SURGERIES FOR THIS PROBLEM:

Special Tests: X-ray MRI CT Scan EMG Nerve Conduction

Have you received Therapy before: Yes / No For this problem: Yes / No

Have you been advised by a physician to avoid any exercise? Yes / No

Do you have legal paperwork instructing your healthcare providers to “Do Not Resuscitate or (DNR)”? _____ If yes, please provide us with a copy.

PATIENT SIGNATURE: _____ Date: _____

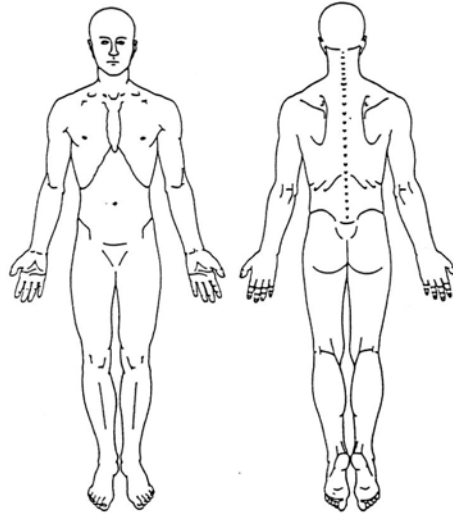
PAIN ASSESSMENT

Patient Name: _____ **Your Chief Complaint** _____

On the Body Diagram please **mark** the area(s) where you have pain.

Indicate your pain type by **circling** a letter or letters:

- A) Deep (inside)
- B) Constant
- C) Intermittent
- D) Aching
- E) Burning
- F) Shooting/Radiating
- G) Sharp
- H) Dull
- I) Other: _____



Rank your pain level(s) on the number scale by **circling** the level of pain you have felt recently.

0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
(no pain) (emergency room pain)

What are you having difficulty doing at home or work because of this current problem?

What are your goals for Physical Therapy? (For example: learn to control pain, return to usual activities, etc?) _____

THERAPIST SIGNATURE: _____ **Date:** _____

PT: _____ DX: _____

PERSONAL INFORMATION

DATE: _____ REFERRING DOCTOR: _____

LAST NAME: _____ FIRST _____ M.I. _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

SOCIAL SECURITY #: _____ SEX: M / F BIRTH DATE: _____

MARITAL STATUS: M S D W ARE YOU UNDER 18? YES / NO

EMPLOYER: _____ RETIRED: YES/NO

DATE OF INJURY: _____ AUTO: YES / NO WORKERS COMP: YES / NO

POLICYHOLDER INFORMATION

NAME OF INSURED: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ PHONE: _____

SS#: _____ DATE OF BIRTH: _____ EMPLOYER: _____

INSURANCE INFORMATION

INS COMPANY: _____

PRIVACY NOTICE

We at Foothills Orthopedic & Sport Therapy, P.C. feel that your privacy should be protected. In the course of your treatment, we collect personal information about you that is necessary to treating you. As our valued patient, we treat this information as confidential and recognize the importance of protecting it. A copy of our complete HIPPA Notice of Privacy Practices is available upon request. By signing below, I acknowledge that I have been permitted to access and/or have a copy of this information.

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient at **FOOTHILLS ORTHOPEDIC & SPORT THERAPY, P.C. (RAY PHYSICAL THERAPY IS A DIVISION OF FOOTHILLS)**

SIGNATURE OF PATIENT OR GUARDIAN

DATE