HAYWARD PHYSICAL THERAPY & WELLNESS

Patient's Full Name (Last, First, MI)			
Address	City	State	Zip
Birth Sex ( )Male ( )Female	SSN (VA pt's only)		DOB
Home Phone Ok to Leave Msg( )	Cell Phone Ok to leave Msg ( )	Work Phone Ok to leave Msg ( )	
How would you like to notified of appointments:	( )Text ( )Phone Call ( )Email ( )All		
Email	Appointment Availability		
Primary Care Physician:			
Emergency Contact/Release of Information	Relationship	Phone	

Financial Policy

In the interest of good health care practice, it is desirable to establish a policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health, and we wish to spend our time and energy towards that end. Therefore, we wish to clarify the following:

Explanation of Insurance Billing and Coverage:

- We will prepare and deliver a medical claim for all costs of your care if you present your current health insurance card during your office visit. **This service is not a guarantee that we have a contractual relationship with your insurance plan and cannot guarantee that your specific insurance policy covers the services that we will provide. IE: Dry Needling, Iontophoresis, or physical therapy services**
- You have provided _____ for insurance please note if there is a change and you do not inform us you may receive a bill.
- We have verified your insurance coverage as a courtesy to you and based on your benefits we will require a payment of _____***at each visit to be*** **applied towards your final balance** ***which is based on Deduct and OOP***.
- We will submit a claim to your insurance carrier as a courtesy to you and bill you directly for any additional ***co-payment, co-insurance***_____, ***deductible***_____, Out ***of Pocket max***_____, non-covered charges, or denied services.
- You should hear from your insurance company within 30 days of your treatment. If you do not, or you believe that your insurance company has not paid your claims correctly, you should contact your insurance company to negotiate a solution. We do not have a way to access the terms and conditions of your insurance policy and are therefore unable to speak on your behalf to your insurance company about contract disputes that you have.
- ***We do not accept litigated claims, third party claims, or letters of protection and will require payment at the time of service.***
- **In case of a disputed Worker's Compensation or Auto Accident claim,** we will bill the patient's health insurance company that was provided on file**. If there is no health insurance, the patient is responsible for payment.**

Explanation of Patient Billing:

- **In the event of Medicare not covering services, the patient is responsible for payment.**
- **In the event of Private Insurance not covering services, the patient is responsible for payment.**
- You will receive a statement from us monthly once you have a balance due. Your payment to us is due to us within 10 days of the statement date.
- If not paid according to terms, you understand that our office reports to an outside collection agency. In the event that your account is turned over for collections you agree to pay all additional fees assessed in the collection of the debt. These fees include collection agency fees and attorney fees.

I have read the above information and by signing below acknowledge my financial responsibility and agree all information provided is accurate, current and complete.

Signature	Today's Date:

Name_____

Date: _____

HAYWARD PHYSICAL THERAPY & WELLNESS

Please check the following conditions as they apply to you:

- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Autoimmune Disorder
- ☐ Cancer
- ☐ Cardiac Conditions
- ☐ ***Cardiac Pacemaker*** **Circle** YES
- ☐ Chemical Dependency
- ☐ Circulation Problems
- ☐ Currently Pregnant
- ☐ Depression
- ☐ Diabetes
- ☐ Dizzy Spells
- ☐ Emphysema/Bronchitis
- ☐ Fractures
- ☐ Fibromyalgia
- ☐ Gallbladder Problems
- ☐ Headaches
- ☐ Hearing Impairment
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Incontinence
- ☐ Kidney Problems
- ☐ Metal Implants
- ☐ MRSA
- ☐ Multiple Sclerosis
- ☐ Muscular Disease
- ☐ Osteoporosis
- ☐ Parkinsons
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Smoking
- ☐ Strokes
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Vision Problems
- ☐ Other_____

Is there anything your practitioner needs to know for Dry Needling

1.	Have you ever fainted or experienced a seizure?	YES	NO
2.	Do you have a pacemaker or any other electrical implants	YES	NO
3.	Are you currently taking blood thinners (e.g. aspirin, warfarin, Coumadin)?	YES	NO
4.	Are you currently taking antibiotics for an infection?	YES	NO
5.	Do you have a damaged heart valve, metal prothesis or other risks of infection?	YES	NO
6.	Are you pregnant or actively trying for a pregnancy?	YES	NO
7.	Do you suffer from metal allergies?	YES	NO
8.	Are you diabetic or do you suffer from impaired wound healing?	YES	NO
9.	Do you have Hepatitis B, Hepatitis C, HIV, or any other infectious disease?	YES	NO
10.	Have you eaten in the last two hours?	YES	NO

1. Are you currently taking any medications? Y / N If **yes**: Is list attached Y/N OR please list below:

Medication_____Dosage_____Reason for taking:_____

Medication_____Dosage_____Reason for taking:_____

Medication_____Dosage_____Reason for taking _____

2. Height_____**Weight**_____

3. Have you had any past surgical procedures? Y / N

If yes, please list and include month and year:_____

4. Are you currently pregnant? Y / N **Or have you been in the last year?** Y / N

5. Do you smoke? Y / N **Do you drink alcohol?** Y / N

6. Have you received physical therapy previously? Y / N

7. Is this work related? Y / N **Is this related to an auto accident?** Y / N

8. Please describe your injury and location of pain:_____

9. How and when did it start?_____

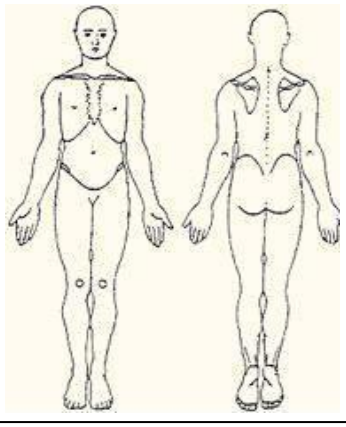
10. Does your current problem interfere with any of the following:

- ☐ Reading
- ☐ Combing hair
- ☐ Bending over
- ☐ Climbing stairs
- ☐ Walking
- ☐ Lifting a gallon of milk
- ☐ Standing
- ☐ Driving
- ☐ Reaching overhead
- ☐ Writing a letter
- ☐ Sitting
- ☐ Dressing

Please circle your level of pain:

0 1 2 3 4 5 6 7 8 9 10

0 being no pain **10 go to emergency room**



Please mark area of pain

Communication Consent

____ Call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out physical therapy, such as appointment reminders, insurance items and any calls pertaining to my clinical care.

____Mail to my home or other alternative location any items that assist the practice in carrying out physical therapy, such as appointment reminder cards and patient statements.

____E-mail to my home or alternative location any items that assist the practice in carrying out physical therapy, such as appointment reminders, patient statements and correspondence.

_____(E-mail address)

____Text messaging consents to send appointment reminders to my cellular device via text messaging. Spooner Physical Therapy and Rehab Specialists are not responsible for any carrier charges that may apply to this form of communication. Phone number:_____

By signing this form, I am consenting to allow Spooner Physical Therapy and Rehab Specialists to use and disclose my personal health information to carry out physical therapy.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Spooner Physical Therapy and Rehab Specialists may decline to provide treatment to me.

Signed by:_____Date:_____

Print Patients name:_____

Print Name of Legal Guardian, if applicable_____

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314 Service Road Spooner WI 54801 PH:715-635-2518 FX:715-635-2672
spoonerpt.net

Designation for release of Medical Information to a Family Member, Friend, or Legal Representative.

It is a clinical staff's responsibility to ensure that the provider-patient relationship is confidential. The Health Portability and Accountability Act (HIPAA) allows providers to use their professional judgment on disclosing certain personal health information to family, friends, etc without an authorization. This form is an aid to the clinical staff in making a determination on disclosing such information. Spooner Physical Therapy & Wellness realizes that there are times when you, the patient, may want another person to be knowledgeable about your condition, needs or treatment plans including appointment times and account status. We want you to be able, if you so desire, to name a person to whom you want the office staff able to speak with about your treatment, visits or other pertinent information. To enable that, we would ask that you complete the form listed below. Please note the following points prior to signing:

- Only one person can be designated for this role.
- The designation is valid until you cancel it in writing
- If you designate no Spooner Physical Therapy & Wellness will not release information to any family member, friend or legal representative.

Designation Statement

I, _____, designate the following person to be able to speak to my provider at Spooner PT&W, or other staff members, should it be necessary, on my behalf. I hereby give permission to Spooner PT & W, though its clinical providers and staff to release to my designee any information about my medical condition or treatment or the status of my account and I release Spooner PT &W its providers and staff, from status of my account and I release Spooner PT & W its providers and staff, from any claim of confidentiality in connection with the release of this information.

Name of Designated Person: _____

Relationship: _____Phone Number: _____

Patient's Sigature: _____

Date: _____ Witness: _____

I Decline to designate another person to speak with my provider or clinical staff:

Patient's Sigature: _____

Date: _____Witness: _____

New Patient Acknowledgements

Patient Name:_____

Notice of Privacy Practices: I HAVE BEEN INFORMED OF MY PRIVACY RIGHTS and have been offered the Notice of Privacy Practices by Spooner Physical Therapy & Wellness.

Authorization to Release / Obtain Information: I AUTHORIZE RELEASE OF ANY PERSONAL OR HEALTH INFORMATION to third party payers, government agencies, healthcare providers or any other organizations that may assist Spooner Physical Therapy & Wellness in meeting my healthcare needs and in order to secure payment for services rendered. Further, I authorize SPTW to obtain needed information from my physician, insurance company, adjuster, attorney and any other health care organization pertinent to my case. These correspondences can be made via mailings, telephone and or facsimile.

Insurance Payments: I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO Hayward Physical Therapy & Wellness and have read and agree to the above stated financial policies.

Consent to Treatment: I CONSENT TO ANY THERAPY, TREATMENT, OR FACILITY SERVICES rendered under the general and special instructions of the therapist assigned to care for me. I agree and consent to Spooner Physical Therapy & Wellness to furnish care and treatment considered necessary and proper in diagnosis and treatment of my physical condition.

Dry Needling Statement of Consent: I confirm that I have read and understood the information provided and I consent to having dry needling treatments performed at Spooner or Hayward Physical Therapy and Wellness Center.

Appointments / Cancellations: Appointments must be cancelled at least 24 hours prior to the scheduled appointment time. In the event a patient arrives late to their appointment and cannot be seen by the provider on the same day, they will be rescheduled for a future clinic visit, if available. There will be a ***$5.00 penalty fee*** for patients who ***"no-show"*** their appointments. Once a patient accumulates a total of $15.00or three (3) ***"no-shows"*** their future appointments will be removed until the cancellation fee has been paid and the patient converses with the physical therapist or business manager about future appointments. In the event a patient has incurred three (3) ***documented "no-shows" the patient may be subject of dismissal from Spooner/Hayward Physical Therapy and Wellness.*** The patient's chart is reviewed, and dismissals are determined by the physical therapist and /or business manager only, with no exceptions. In the event of ***three (3) documented "same-day cancellations***," in one month, ***the patient may be subject to dismissal from Spooner/Hayward Physical Therapy and Wellness***. The patient's chart is reviewed, and dismissal are determined by the physical therapist and or business manager only.

Communication Consent: I consent to allow Spooner Physical Therapy and Wellness to use and disclose my personal health information to carry out Physical Therapy. I may revoke my consent in writing except to the extent that the practice has already made disclosures.

Designation for Release of Information to Family Member, Friend, Or Legal Representative: I designate my ***Emergency Contact*** to be able to speak to staff at Spooner PT&W on my behalf. I give permission to Spooner PT&W, through its clinical providers and staff to release to my designees any information about my medical condition or treatment or the status of my account and I release Spooner PT&W, its providers and staff, from status or my account and I release Spooner PT&W, its providers and staff, from any claim of confidentiality in connection with the release of information.

- *Only one person may be designated for this role.*
- *The designation is valid until it is cancel in writing.*

Photo/Video Usage:I understand that any photo or video image(s) taken while in the offices of Hayward Physical Therapy & Wellness might be used in print and/or on-line and/or social media publication, advertisement, and in any other format that Spooner Physical Therapy chooses. Please note we have large windows are not responsible for photos taken of the building that you may be in.

The undersigned patient or Responsible Party acknowledges that he/she has read and agrees to the information printed above.

Signature	**Today's Date**