Science Applied Artfully

Paradigm

Physical Therapy & Wellness

Cancellation/No Show Policy

Paradigm Physical Therapy requires 24 hour notice for the cancellation of a scheduled appointment. There is a $50.00 charge for a No-Show or Cancellation without proper notice. This charge will not be covered by your insurance. We understand that extenuating circumstances may occur which is why we have implemented a "Two Cancel and/or No Show" policy. We will allow for two cancellations before charging a fee. For every cancellation or no-show beyond two, a $50.00 fee will be assessed. Maintaining regular treatment sessions is essential for positive outcomes. Repeated cancellations and/or no-shows will hinder your care and may result in discharge from our clinic.

Lateness Policy

It is equally important that you be on time for your scheduled appointment. You are welcome to call in advance to request an earlier or later time. We will be happy to honor your request if other appointment times are available, however, simply arriving late or early changes the course of treatment for yourself and others. We cannot guarantee that we will be able to treat you if you are more than 10 minutes late for an appointment. Similarly, you may be asked to wait until your scheduled appointment time if you arrive more than 10 minutes early for your appointment. In order to provide you with the best possible care, we ask that you arrive at the time of your appointment.

We take these policies seriously because when a patient misses an appointment, three people are adversely affected:

1. *You, the patient – for not receiving the treatment you need.*
2. *Your therapist – as now he or she has a gap in the schedule.*
3. *Another patient – who could have had your appointment time.*

Please understand your pain may fluctuate as your course of treatment progresses and before you complete therapy. Having pain or not having pain are NOT reasons to cancel or fail to show for your scheduled treatment. If you are in pain, it is important to come in because there are treatments available and/or program modifications that can help lessen your pain. Likewise, if you are experiencing less pain, it is important to continue your course of treatment to correct the underlying causes of your injury which will prevent future setbacks.

I consent to the above, as indicated by my signature below:

Print Name

Signature **Date**

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Patient Consent to Responsible Party

I _____ give my consent for the following person(s)
(Print Patients Name)

_____, _____, _____
Print Responsible Party Name(s)

to have and handle the following aspects of my care at Paradigm Physical Therapy:

- *Access to my financial information, in order to pay any deductible, co-insurance or copay payments or any other payments on my account.*
- *Ability to schedule, cancel and/or discharge therapy appointments.*
- *Ability to acquire information from the Physical Therapist or Physical Therapy Assistant regarding my treatment at Paradigm.*
- *Any other information specified by patient. Please list below:*

_____ _____
Patients Signature ***Date***

_____ _____
Responsible Party Signature ***Date***

_____ _____
Responsible Party Signature ***Date***

_____ _____
Responsible Party Signature ***Date***

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SCHEDULING POLICY AND PATIENT CONSENT

I do hereby give consent to Paradigm Physical Therapy & Wellness to perform Physical Therapy, to release any medical and billing information necessary to process insurance claims for my medical services, and I give permission to fax and release medical information to my referring Medical provider and any Medical provider involved in the care of my present condition. I also permit a copy of the authorization to be used in place of the original.

Minor children under the age of 14 must be accompanied by a parent or guardian during their treatment time.

In the case of Minor children 14 years or older that are dropped off or transport themselves, my Parental signature below authorizes continued treatment and releases Paradigm of any liability for the transportation period to and from our clinic.

I have read the above policies and do agree to the terms.

_____ _____

Patient Signature *Date*

_____ _____

(If minor) Parent/Guardian Signature *Date*

Please inform us in advance of your next scheduled appointment with the Doctor who referred you to our office. This will enable us to keep your physician informed of your progress.

PARADIGM PHYSICAL THERAPY AND WELLNESS

Please initial the applicable paragraphs, including the last two that apply to ALL patients.

_____For Managed Care or Commercial (HMO, PPO) *patients - co-pays, co-insurances and deductibles are due at the time of service. If your insurance plan requires prior authorization, the business office will obtain this prior to your appointment. Prior authorization is not a guarantee of payment. If your insurance is terminated or you are ineligible for services at the time they are rendered, you will be responsible for payment in full.*

_____For our Medicare *patients - Paradigm Physical Therapy is a participating provider, therefore, all covered services will be billed for you. If you have a supplemental or secondary insurance coverage, we will submit claims directly for your convenience. You are responsible for all deductibles, co-insurances and non-covered services. If you do not have a secondary or supplemental policy, you will be responsible for a 20% coinsurance due at the time of service.*

***Are you currently receiving or have you had any Home Health Care in the last sixty days?* **YES____ NO_____ IF YES, When? _____.**

***** If you have received Home Health Care within the last 60 days you will be liable for all services.***

***Have you had any previous Physical Therapy treatment this year? YES_____ ___ NO ____*

_____For Centennial Care/Medicaid *patients –Paradigm Physical Therapy will bill all services directly. If services are denied for reasons of expired eligibility, payment in full will be expected at the time of service. Please note proof of eligibility is required at the time of service. Patient is responsible for notifying us if eligibility is lost.*

_____Workers Compensation patients *– Paradigm Physical Therapy will bill all services directly upon receipt of authorization from the Workers Compensation Insurance carrier.*

_____For our Self-Pay *patients - Patient will be responsible for payment in full at time of service based on Paradigm's fee schedule.*

_____For our Accident (1st Auto) *patients –The patient must disclose to Paradigm Physical Therapy the amount of your policies medical payment limitations at the time of service. Paradigm Physical Therapy will bill all services directly. If your medical payment coverage is exhausted, or claims are denied you will be responsible for the entire balance of your bill.*

_____ For Patients with a HRA Account-*If monies are designated to the patient, the patient will be responsible for paying any deductible, coinsurance/co-pay or any amount not covered by the insurance plan at the time of service. If the HRA is in Credit Card form, the patient may pay for services with the HRA Credit Card at the time of service. If the HRA is designated to the providers, the patient will still be required to pay for any deductible, coinsurance/co-pay or any amount not covered by the insurance plan at the time of services and can be reimbursed by their HRA account.*

_____ For Patients with a Secondary Insurance *we will file as a courtesy, however, Paradigm Physical Therapy is bound by the primary insurance contract and follows the rules of said contract to collect all co-pays, co-insurances and deductibles at the time of service. If the secondary insurance pays additional funds Paradigm Physical Therapy, we will refund any monies due to the patient in accordance to the refund policy. If the secondary payer states there are no additional monies to be paid to Paradigm Physical Therapy the patient is still responsible for all copays, coinsurances, deductibles and non covered services as directed by the primary insurance contract. (With the exception of Medicaid or Medicare as a secondary payer)*

Paradigm Physical Therapy will contact your insurance carrier to verify coverage as a courtesy. Paradigm Physical Therapy does not guarantee any quotes given to us by your insurance carrier. It is the patient's responsibility to know their own policy coverage, limitations and exclusions.

____ Payment of any uninsured charges is expected within 30 days of final billing, unless other arrangements are made.

____ Interest will be charged on all billings not paid within said time limit at the rate of 18 percent (18%) per year applied against the unpaid balance. Should a past due bill be referred for collection, you will be responsible for all reasonable collections costs, including our reasonable attorney's fees and legal costs.

A $35.00 FEE WILL BE ASSESSED FOR EVERY INSUFFICIENT FUND NOTICE WE RECEIVE FROM YOUR BANK

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION REGARDING PARADIGM PHYSICAL THERAPY'S FINANCIAL POLICIES. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ANY BALANCE DUE ON MY ACCOUNT AFTER ALL PAYMENTS AND CONTRACTUAL OBLIGATIONS HAVE BEEN RECORDED. MY SIGNATURE BELOW AUTHORIZES MY INSURANCE CARRIER TO ASSIGN BENEFITS DIRECTLY TO PARADIGM PHYSICAL THERAPY.

_____ _____

Patient/Guardian Signature **Date**

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ACKNOWLEDGEMENT OF PRIVACY RIGHTS

My signature confirms I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand this information can and will be used to:

- □ *Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.*
- □ *Obtain payment from third-party payers for my health care services.*
- □ *Conduct normal health care operations such as quality assessment and improvement activities.*

I understand I must be notified in writing of any changes in disclosures or restrictions of information other than stated above.

_____ _____

Patient Name *Date*

_____ _____

(If minor)Parent/Guardian Signature *Date*

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REFUND POLICY

Due to the uncertainty of deductible, co-pay, and co-insurance amounts due at the time of service, Paradigm Physical Therapy may collect in error for these amounts. A reconciliation of your account will occur 30 days after treatment has ended and 30 days after all payments are received from insurances. A refund will be issued within 30 days of your account reconciliation. Special circumstances will be reviewed on a case by case basis.

_____ _____

Patient Signature *Date*

_____ _____

(If Minor)Parent/Guardian Signature *Date*

PARADIGM PHYSICAL THERAPY AND WELLNESS

Do you have or have you ever had……..
Heart Disease……..Yes/No
Heart Attack……Yes/No
Heart Surgery……..Yes/No
Angina……..Yes/No
COPD……..Yes/No
CVA/Stroke……..Yes/No
TIA……....Yes/No
High Blood Pressure…….....Yes/No
Asthma or Pulmonary Disease……..Yes/No
Diabetes……....Yes/No
Ulcer or Stomach Disease……Yes/No
Bowel Disease……...Yes/No
Kidney Disease……..Yes/No
Liver Disease……....Yes/No
Anemia or other Blood Disease……..Yes/No
Overweight……....Yes/No
Cancer……....Yes/No
Depression……Yes/No
Osteoarthritis……Yes/No
Rheumatoid Arthritis……Yes/No
Osteoporosis/Penia……....Yes/No
Back Pain……...Yes/No
Lyme Disease……Yes/No
Bronchitis……...Yes/No
Seizures……..Yes/No
Allergies……Yes/No
Headaches……..Yes/No
Rheumatic Fever……....Yes/No
Sexually Transmitted Disease……...Yes/No
Alcoholism……Yes/No
Have you ever had surgery……Yes/No
If yes elaborate_____
_____
_____
_____
_____

Other Medical Problems_____
_____
_____

_____
Patient/Guardian Signature

Do you have problems with……
Hearing……...Yes/No
Vision……Yes/No
Speech……....Yes/No
Communication……..Yes/No

In the past 3 months have you had…
A change in your health……Yes/No
Nausea or vomiting……Yes/No
Fever, chills, or sweats……....Yes/No
Unexplained weight changes..Yes/No
Numbness or tingling……...Yes/No
Changes in appetite……..Yes/No
Difficulty swallowing……...Yes/No
Changes in bowel or bladder function……....Yes/No
Urinary tract infection……..Yes/No
Shortness of breath……...Yes/No
Dizziness……Yes/No
Upper respiratory infections....Yes/No

Are your symptoms (check one)
_____*Getting worse*
_____*The same*
_____*Improved*

How do you sleep at night…
_____*Fine*
_____*Difficulty*
_____*With medication*

Female patients only…
Are pregnant……...Yes/No

Are you currently…
Under stress……Yes/No
Depressed……Yes/No
Do you have a history of Depression……...Yes/No

Do you or have you ever smoked or chewed tobacco……..*Yes/No*

Do you drink alcohol…….*Yes/No*
If yes, how many drinks do you average per week? _____

_____
Date

In general, how would you say your health is…

_____*Excellent* _____*Very Good*
_____*Good* _____ *Fair*
_____*Poor* _____*Same*

Activity Level

Do you work out?

_____*Light: 1 to 2 times/week*
_____*Moderate: 3 to 4 times/week*
_____*Heavy: 4 to 6 times/week*

Date of last physical exam_____

List all medications currently taking:

_____
_____
_____
_____
_____
_____
_____
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_____
_____
_____

Dosage:

_____
_____
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_____
_____

Highest level of education completed…

_____*Less than high school*
_____*Graduated from high school*
_____*Graduated from college*
_____*Postgraduate school or degree*

_____ _____
Patient Signature *Date*

_____ _____
(If Minor)Parent/Guardian *Date*