ACOSTA
PHYSICAL THERAPY, LLC

PATIENT INFORMATION

Date: _____

Name: _____

Age: _____ Date of birth: _____

Address: _____

Primary phone: _____ Alternate phone: _____

Email: _____

Occupation: _____ Employer: _____

Employer phone number: _____

Emergency contact name: _____

Emergency phone: _____ Relationship: _____

Primary care physician: _____

Do you have a referral for PT? yes ☐ no ☐

Would you like a receipt to submit an invoice to your insurance or flexible spending account/health savings account? yes ☐ no ☐

Are you seeking physical therapy treatment for a work-related or motor vehicle accident-relatedinjury? yes ☐ no ☐

ACOSTA PHYSICAL THERAPY
3650 MAYBERRY DR. SUITE 101-6 RENO, NV 89509
PHONE: 775-235-2834 FAX: 702-820-2654
BRENDAN@ACOSTAPHYSICALTHERAPY.COM

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HISTORY AND INTERVIEW

Date: _____

Patient name: _____

Age: _____ Height: _____ Weight: _____

Area being treated and/or medical diagnosis by your doctor: _____

Are you currently working? yes ☐ no ☐ Brief job description: _____

_____

Where and when did the pain and/or symptoms start? _____

_____

Are your symptoms associated with an injury? _____

Has the pain spread? yes ☐ no ☐ If yes, where? _____

Where is the pain now? _____

Describe the pain using adjectives such as:

throbbing ☐ burning ☐ aching ☐ sharp ☐ dull ☐ tingling ☐ other: _____

Do you have numbness or pins and needles? yes ☐ no ☐ if yes, where? _____

Is your pain: ☐ Constant 75-100% ☐ Frequent 50-75% ☐ Occasional 25-50% ☐ Intermittent 0-25%

Do you get any increased pain with the following?

AM _____ PM _____ Rest _____ Walking _____ Standing _____ Sitting _____ Night (sleep) _____ Rising from sitting _____

What increases your symptoms? _____

What eases your symptoms? _____

Do you have a problem with bowl or bladder function?

if yes, describe: _____

Check the diagnostic tests that have been performed: yes ☐ no ☐

MRI ☐ CT Scan ☐ X-Rays ☐ Bone scan ☐ EMG ☐ Discogram ☐ other: _____

Describe any treatment (ie. MD, Chiropractic, Acupuncture, P.T., Surgery, massage therapy) that you have received relating to this injury and its effectiveness: _____

_____

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PAST HISTORY

1. Previous history of similar symptoms? yes ☐ no ☐
2. History of falls? yes ☐ no ☐ If yes, when was the most recent? _____
3. Have you experienced unexplained weight loss in the last six months?
   a. If yes, describe: _____
4. Previous surgeries? _____

Please circle YES or NO for the following conditions:

Anemia	YES	NO	Diabetes	YES	NO	Incontinence	YES	NO
Anxiety	YES	NO	Digestiver Disorders	YES	NO	Kidney Problems	YES	NO
Arthritis	YES	NO	Dizzy Spells/Fainting	YES	NO	Metal Implants	YES	NO
Autoimmune Disorder	YES	NO	Emphysema/Bronchitis	YES	NO	Multiple Sclerosis	YES	NO
Cancer	YES	NO	Fibromyalgia	YES	NO	Muscular Disease	YES	NO
Cardiac Conditions	YES	NO	Fractures	YES	NO	Osteoporosis	YES	NO
Cardiac Pacemaker	YES	NO	Headaches	YES	NO	Rheumatoid Arthritis	YES	NO
Chemical Dependency	YES	NO	Hearing Impairment	YES	NO	Seizures	YES	NO
Circulation Problems	YES	NO	Hepatitis	YES	NO	Speech Problems	YES	NO
Currently Pregnant	YES	NO	High/low Blood Pressure	YES	NO	Sleep Disorder	YES	NO
Degenerative Disc/joint Disease	YES	NO	High Cholesterol	YES	NO	Stroke	YES	NO
Depression	YES	NO	HIV/AIDS]	YES	NO	Thyriod Disease	YES	NO
						Vision Problems	YES	NO

If answered "yes" to any of the above, please explain and describe any other conditions:

_____

_____

Do you have any allergies? yes ☐ no ☐ If yes, which? _____

Current medications: _____

What are three goals you want to achieve through PT?

1. _____
2. _____
3. _____

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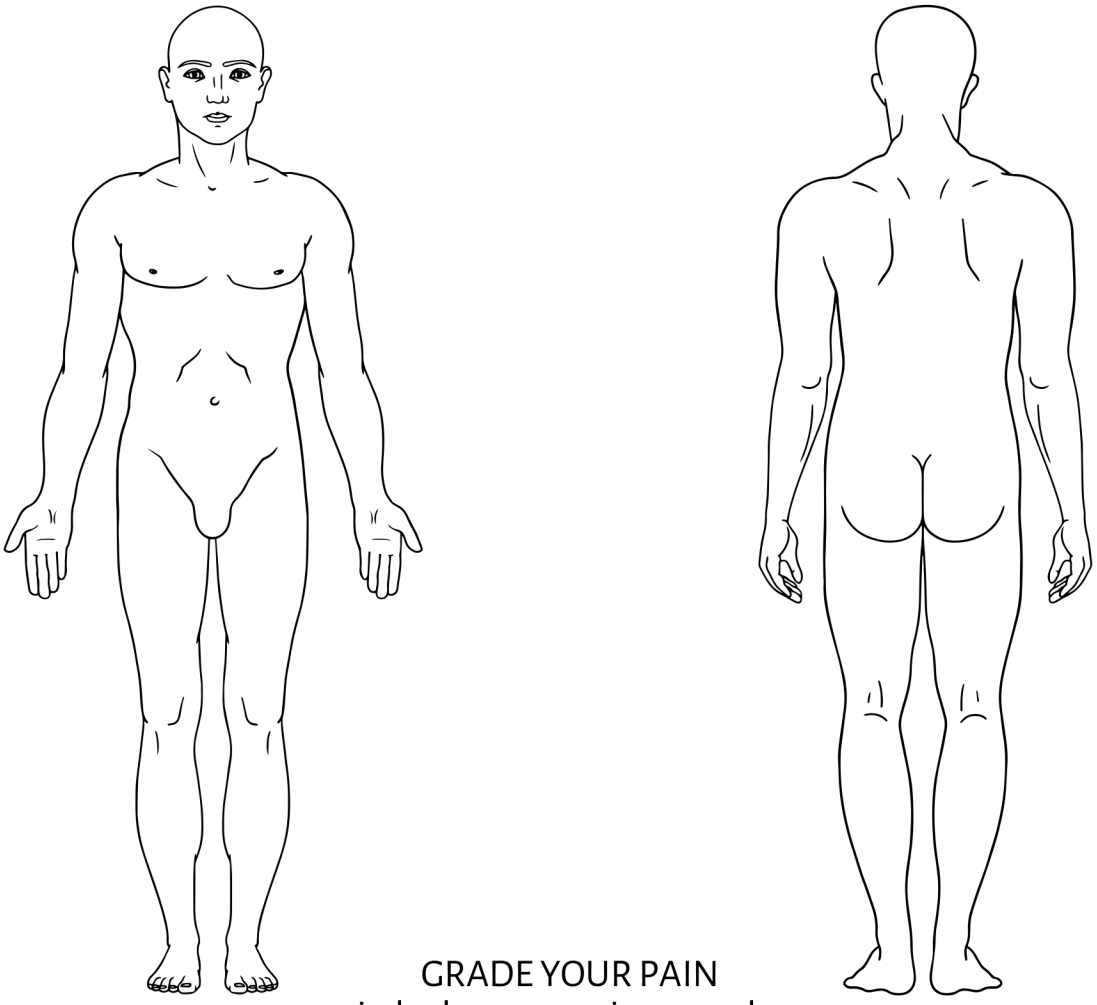
PAIN DRAWING GRID ASSESSMENT

Draw the location of your pain on the body using the symbols listed directly below

ACHES	BURNING	NUMBNESS	PINS & NEEDLES	STABBING	OTHER
////////	BBBBB	XXXXX	========	ZZZZZ	OOOOO



GRADE YOUR PAIN
circle the appropriate number

no pain — intolerable pain

0 1 2 3 4 5 6 7 8 9 10

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have been given a copy of or an opportunity to read the practice's Notice of Privacy Practices.

_____ _____

Patient's or Guardian's Signature Date

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CONSENT TO EXAMINATION AND TREATMENT

I hereby consent to a physical therapy examination and subsequent treatment as recommended by the examining physical therapist.

Examination. I understand the examination includes providing a medical, social and physical activity history and reporting of my symptoms and complaints. I agree to allow the physical therapist to perform all physical tests and measures required to identify my physical therapy diagnosis, problems and prognosis. I understand that some tests and measures may require the physical therapist to perform a visual inspection of exposed body areas or palpate body parts that are sensitive or painful. I also understand that there are some risks in participating in a physical examination, including but not limited to developing soreness, increased pain, new pain in different areas, an aggravation of existing symptoms or a new injury. I understand that if I am uncomfortable at any time during the examination, I can let the therapist know and may refuse to continue the examination at my choice. If I refuse to participate in any part of the examination, I understand that the physical therapist may not be able to provide an accurate physical therapy diagnosis/prognosis or develop the most appropriate treatment plan.

Treatment. I acknowledge that my physical therapist (hereinafter "PT") has informed me of my diagnosis, prognosis and the potential risks and benefits of all recommended interventions in my proposed plan of care and I have been given an opportunity to have all my questions answered. I hereby agree to participate in and consent to receive the physical therapy interventions recommended by my PT as outlined in my treatment plan. I understand that the response to different physical therapy interventions varies from person to person and sometimes treatment interventions may result in increased pain, an aggravation of existing symptoms or a new injury. Therefore, I agree to inform my PT of any change in my symptoms and function so my treatment plan can be adjusted accordingly. I understand that I may decline any intervention at any time by informing my PT of my desires/concerns and that my refusal may result in a termination of my treatment if my PT determines that there are no other treatment alternatives or the refused intervention is essential to meeting my goals. I also understand that although we have set rehabilitation goals, my PT has made no guarantees that any particular outcomes will result from the therapy interventions.

I have read and understand the benefits and risks involved in participating in a physical therapy examination and treatment. I consent to the examination and treatment, accept any and all associated risks involved and agree to fully cooperate and participate in the proposed physical therapy interventions in the established plan of care.

Patient's Name (Printed) _____

Patient's Signature _____ Date_____

Parent/Guardian Signature_____ Date_____

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CONSENT FOR E-MAIL/TEXT COMMUNICATION AND APPOINTMENT REMINDERS

We respect the privacy rights of all our patients and will therefore only communicate with patients and parents/guardians through email, text or voice mail messaging with your written consent. Email can be inherently insecure if your email service does not use encryption. Also, if your email address is through your employer, your employer may have access to your email box. Voice mail may also be insecure, especially if you use a VOIP phone service. When you consent to communicating with us by email, text or phone, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information. Since we do not control the email and phone systems you use, we are not 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 (limiting the information disclosed) 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: _____

Phone number: _____

Patient Signature: _____ Date_____

Parent/Guardian Signature: _____ Date_____

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PAYMENT AGREEMENT

Thank you for choosing Acosta 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 the time of service unless you have made other payment arrangements with us. We accept cash, check, or credit card.
- **Out-of-Network Policy**. (Commercial Health Plans - Does not apply to Medicare) We are out-of-network with all health plans. If you have out-of-network benefits, 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 understand that even if you have out of network benefits, you may be required to pay a higher copay or coinsurance for out of network services and you may have separate out of network deductibles and out of pocket maximums. 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.
- **TriCare Policy**. We are out-of-network with all TriCare Plans. If your TriCare plan will reimburse you for out of network services, we will give you a copy of your bill that you can, at your discretion, submit to TriCare for reimbursement for the services your health plan covers. You are responsible for obtaining any physician referrals and/or pre-authorizations that might be required. Limiting charges apply to all claims that TriCare pays for, so when you receive your explanation from TriCare stating how your claims were processed, please provide a copy to us so we can provide a refund if you paid more than TriCare's allowable fee.
- **Medicare Policy (for Medicare Part B and Medicare Advantage Plans)**. 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. 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. As a condition of us providing services to you, you are choosing, of your own free will, not to use your Medicare benefits and agreeing to pay privately 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 and 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.
    - **Medicare supplemental or secondary insurance plans**. If your Medicare supplemental or other secondary insurance plan will reimburse you for medically necessary services by providers not enrolled with Medicare, we will provide you with a Superbill that you can send to your supplemental or secondary plan to see if they will reimburse you without a Medicare denial. We cannot submit a claim to Medicare just to get a denial since we are not enrolled as a Medicare provider. You should also be prepared that some supplemental plans will not reimburse for services by providers who are not enrolled with Medicare.
    - **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 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 of copays, coinsurance or deductibles that your commercial health plan does not pay.

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- Cancellation Policy. We require a 24-hour notice to cancel a scheduled appointment. If you cancel with less notice or no-show, you will be required to pay a $50 late cancellation/no show penalty fee. We reserve the right to waive this policy at our sole discretion.
- Returned checks. Returned checks are subject to a $25.00 fee, and you will be no longer allowed to pay by check and only allowed to pay by cash or credit card.
- 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.

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 Acosta 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 Acosta Physical Therapy, LLC and my therapist from submitting any claims to Medicare pursuant to my right to privacy under HIPAA.

Patient Name (Print or Type): _____

X _____ Date: _____
Patient's Signature

A photocopy of this agreement is to be considered valid, the same as if it was the original.

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