PARACLETE
PHYSICAL THERAPY

(Please Sign Below and Initial Beside Each Statement…Thanks!)

IMPORTANT APPOINTMENT INFORMATION

FOR INSURANCE PURPOSES - YOU MAY NOT HAVE AN APPOINTMENT WITH RAPPAHANNOCK FOOT & ANKLE SPECIALISTS AND PARACLETE PHYSICAL THERAPY ON THE SAME DAY. INSURANCE WILL ONLY PAY FOR ONE VISIT AT THE SAME FACILITY ON THE SAME DAY. ____ Initial

MISSED APPOINTMENTS:

Because your appointment is designated for only you, there will be a $50 charge for a missed visit if you do not give us 24 hours notice. This notice will allow us to fill your appointment time with someone else who is waiting for an appointment. If you are ill or have an emergency, we can discuss the missed visit fee on an individual basis. ____ Initial

SICK ON YOUR APPOINTMENT DAY:

DO NOT COME TO PT WITH A FEVER! Because we work with everyone on a one-on-one basis, please do not come into PT if you have anything that can passed to your therapist. They will then either be too sick themselves to perform therapy on other patients or pass the illness onto everyone they come in contact with. _____ Initial

VOICEMAIL OPTIONS:

If you call during normal office hours and are not able to reach a live person on the phone or you need to call the office after hours, LEAVE A MESSAGE with your name and the best phone number to reach you on. We will return your call as soon as possible. If there is a potential for an office closure due to inclement weather, etc. please call our RFAS line (540) 371-2724 (opt 6 to leave a message for PT) for closures and/or late openings. _____ Initial

CONSECUTIVE MISSED APPOINTMENTS:

Due to the limited number of physical therapy appointments available and the need for continuance of care, if you miss three PT appointments in a row (without notifying us w/in the 24-hour guideline) then you will be required to see your referring doctor before continuing with PT services. _____ Initial

Patient Printed Name: _____ **Patient DOB:** _____

Patient Signature: _____ **Date:** _____

We Care About Your Health and The Rehabilitation of Your Condition!!!

PARACLETE PHYSICAL THERAPY

Welcome to Our Practice

Please fill out ALL information found below to the best of your ability as it is vital for our records and your treatment.

Patient Name_____ Date_____

Patient Medical History:

Circle if you have ever been treated for any of the following:

Acid Reflux/GERD
AIDS or HIV+ (please circle which one)
Anemia /Blood/Plasma Transfusion
Anxiety/Depression
Arthritis - type: _____
Asthma
Back Trouble
Bladder Infections
Bronchitis
Cancer
Diabetes x _____ yrs.
Epilepsy
GI Ulcer
Glaucoma
Gout
Heart Disease
Hepatitis A , B or C
High Blood Pressure
High Cholesterol
Hives or Eczema
Hyperthyroidism
Hypothyroidism
Kidney Disease
Migraine Headaches
Mitral Valve Prolapse
Pneumonia
Rheumatic Fever
Stroke
Tuberculosis
Venereal Disease

List Any Other Diseases: _____

Review of Systems: (Please indicate personal history below by circling)

CONSTITUTIONAL SYMPTOMS

Good general health lately
Recent Weight Change
Fever
Fatigue

EYES

Eye disease or injury
Wear glasses/contact lenses
Blurred or double vision

CARDIOVASCULAR

Chest pain
Palpitations
Swelling of feet, ankles or hands

RESPIRATORY

Chronic or frequent coughs
Spitting up blood
Shortness of breath
Wheezing

{FEMALES ONLY:}

Are you Pregnant: Yes or No

Are you currently breast feeding: Yes or No

GASTROINTESTINAL

Loss of appetite
Nausea or vomiting
Frequent diarrhea

GENITOURINARY

Kidney disease
Dialysis
Kidney stones

MUSCULOSKELETAL

Joint pain
Joint stiffness or swelling
Weakness in muscles or joints
Muscle pain or cramps
Back pain
Cold extremities
Difficulty in walking
Neuromuscular disease

INTEGUMENTARY (skin)

Rash or itching
Change in skin color
Change in hair or nails
Varicose Veins

NEUROLOGICAL

Frequent or recurring headaches
Light headed or dizzy
Convulsions or seizures
Numbness or tingling sensations
Tremors
Paralysis
Head injury
Stroke

PSYCHIATRIC

Memory loss or confusion
Depression
Insomnia

ENDOCRINE

Diabetes
Glandular or hormone problem
Excessive thirst or urination
Heat or cold intolerance

HEMATOLOGIC/LYMPHATIC

Bleeding or bruising tendency
Anemia
Phlebitis

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need. I understand that I may be asked to update this form every 6 months for continued medical care.

X_____ _____

Signature of patient (or parent if minor) Date

PARACLETE
PHYSICAL THERAPY

PAIN QUESTIONNAIRE

PATIENT NAME: _____ **DATE:** _____

CURRENT PROBLEM: (please explain)

_____

_____

WHEN DID YOUR PAIN START (OR SURGERY DATE?): _____

RATE THE FOLLOWING ON A SCALE OF 0-10 (0=No Pain; 10 = Worst Pain

- **1 - CURRENT PAIN LEVEL?** _____
- **2 - LEAST AMOUNT OF PAIN PAST WEEK?** _____
- **3 - WORST PAIN IN THE PAST WEEK?** _____

DESCRIBE YOUR PAIN: SHARP DULL ACHE THROBBING STABBING BURNING

CIRCLE THE THINGS THAT MAKE YOUR PAIN WORSE:

SITTING STANDING WALKING ASCENDING STAIRS DESCENDING STAIRS BENDING SIT TO STAND VOIDING LYING DOWN COUGHING SNEEZING

WHAT MAKES THE PAIN LESS? _____

DO YOU HAVE ANY PREVIOUS HISTORY OF THESE SYMPTOMS: YES NO

IF YES, WHEN? _____

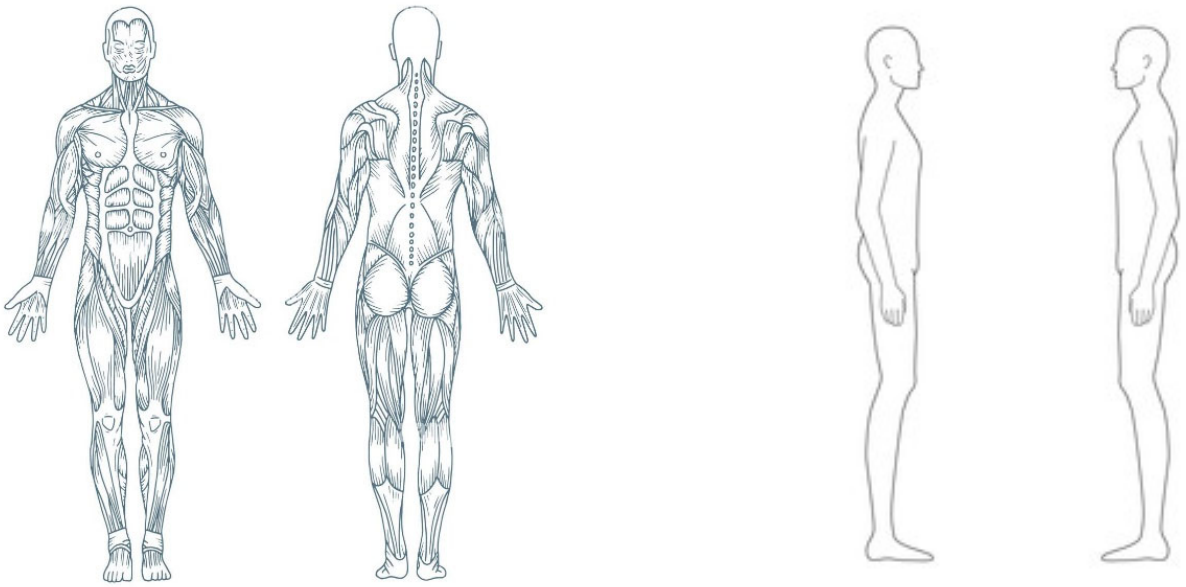
WHAT TREATMENTS HAVE YOU RECEIVED FOR THIS PROBLEMS SO FAR:

_____

WHAT SPECIFIC/FUNCTIONAL GOALS DO YOU HOPE TO ACHIEVE FROM THERAPY:

1. _____
2. _____

PLEASE MARK ON THE DRAWINGS WHERE YOU FEEL YOUR PAIN:



PARACLETE PHYSICAL THERAPY

WELCOME TO OUR OFFICE

Please answer ALL questions to the best of your ability. This information is important for your health and our records. If you need more room for any of the questions, you may flip over to the backside to finish

Dr. Mr. Mrs. Ms. Name - Last_____ First_____ MI _____ Suffix ____

Mailing Address (Street, P.O. Box, Apt #) _____

City:_____ State:_____ Zip(+last4):_____

Physical Address (911 – if different from above)_____

E-mail Address: _____

Phone #: (_____)_____ Cell Phone #: (_____)_____

Work Phone #: (____)_____ Ext:_____ ☐ Full Time Student or ☐ Part Time Student

Date Of Birth:_____/_____/_____ Sex –☐ Male or ☐ Female SS#:_____

Marital Status: ☐Single ☐Divorced ☐Married ☐Partner ☐Separated ☐Widowed Occupation:_____

Employer Name_____

Employer Address: _____

City_____ State_____ Zip_____

Person Responsible if Patient is a Minor:_____

Address & Phone#: (if different from above): _____

Responsible Party Employer Name, Address and Phone #: _____

_____

Social Security Number: _____ DOB: _____

Emergency Contact Information: (Name, Relationship and Phone #)

_____

_____

If you are a patient with military insurance, are you: ☐ Active Duty or ☐ Retired Military

Race: American Indian/Alaskan Native, Asian, African American, Native Hawaiian/Other Pacific Islander, White

Ethnicity: Hispanic or Latino / Not Hispanic or Latino Preferred Language: _____

Primary Care Physician (Not Facility) & Phone Number: _____

Referring Physician & Phone Number: _____

PLEASE NOTE: PAYMENT IS EXPECTED IN FULL AT THE TIME OF SERVICE, unless insurance information or an insurance claim form is provided at the time of service. Also, upon visit you will be responsible for any co-pay/deductible/your percentage that has not been met at the time of service. Claims pending over (6) weeks will be your responsibility. Any payment received from your insurance company greater than your outstanding balance will be refunded to you or the insurance company. You are responsible for anything that is not covered by your insurance for today's visit. We bill insurances as a courtesy. If there is any information we request and feel is important for the billing process, (i.e. SSN, Physical address, etc.) and you are not willing to give this information to us you will be responsible for payment in full the date of service and to submit claim to your insurance company yourself. This also authorizes a credit report to be acquired by us if an account is to be established.

_____ _____

Signature Date

PARACLETE
PHYSICAL THERAPY

TREATMENT/FINANCIAL POLICIES

(PLEASE READ ALL OF THE BELOW BEFORE SIGNING. NOT SIGNING OR MARKING THROUGH THIS FORM DOES NOT ELIMINATE YOU FROM ANY OF OUR POLICIES, IF YOU CONTINUE WITH TREATMENT, THESE POLICIES CAN STILL BE ENFORCED)

TREATMENT CONSENT

I hereby authorize and consent to treatment at Rappahannock Foot & Ankle Specialists, PLC. This may include the administration of medications, diagnostic tests and procedures as deemed necessary by my physician, or his assistants or designees, for purposes of diagnosis or treatment. I also agree to have blood work performed should any of the employees of Paraclete Physical Therapy accidentally get stuck or cut with a needle or blade that has been used on me.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Rappahannock Foot & Ankle Specialists, PLC to release any and all information to insurance companies or associations, employee groups, employer, government agencies or their third-party payers and their agents or employees, either by mail or electronically as: may be necessary for completion of all my claims. If said records should be received by another party in error, I absolve the practice of any liability related to such submission of said records.

AUTHORIZATION TO LEAVE MESSAGES

I authorize the staff of Rappahannock Foot & Ankle Specialists to leave a message on my home voice mail, answering machine or other electronic device, or with a person who answers my home phone in regards to my health, my appointment or my financial obligations to the practice.

TERMS FOR UNDERSTANDING PAYMENTS/ADJUSTMENTS APPLIED:

DEDUCTIBLE: an amount you must pay first out of your own pocket each year before your insurance will pay for any service.

CO-PAY: an amount you must pay before each visit to a doctor designated by your insurance company and are due prior to seeing the doctor when you sign in. Co-pay fees vary depending on the insurance plan you opted for or your employer has opted for. Your co-pay may change from year to year and it is your responsibility to know this and inform us of any changes.

ALLOWABLE AMOUNT: Payment amounts your insurance company allows for the charges billed.

CO-INSURANCE: an amount which is usually a percentage of the allowable amount that your insurance company will not pay. For example, if your insurance company pays 80%, you are responsible for 20%.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment to Rappahannock Foot & Ankle Specialists, PLC for any services rendered by the practice subsequent to this date, and for such other charges as may be made by said practice. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance. I understand that health insurance coverage varies and that all services provided may not be covered. It is my responsibility to negotiate payments from the insurance company and while they use such terms as customary, reasonable, prevailing, usually, etc. to limit their coverage, payment of the office charges remains my obligation. If you have two (2) medical insurance plans, it is your responsibility to inform us which plan is your PRIMARY (first) coverage and which plans is your SECONDARY (second) coverage, you must inform us if one or both insurance plans change or are no longer effective.

We will need a copy of the front and back of your insurance card at your initial visit. We expect you to inform us of any change in coverage that may occur and provide us with an insurance card to copy at that time. If you do not have an insurance plan that we have a written agreement with then you are responsible for that day's visit.

Some insurance plans require a referral from your primary care physician. You are responsible for obtaining this referral prior to your visit, or full payment will be expected for the medical services rendered. If your referral expires, we try to call you a week in advance as a courtesy to let you know you need a new referral. This is not always possible, so it is ultimately your responsibility to keep track of your referrals.

SELF-PAY PATIENTS

Patients who do not have health insurance or patients who have health insurance and chose to be self-pay, will be responsible for payment in full are considered self-pay patients. Self-pay patients are required to complete and sign the office's Self-Pay Form prior to receiving services.

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I understand that I will be responsible unless otherwise specified in another written contract, for all services rendered to the patient. I agree to pay for service rendered, in full at time of service, unless other arrangements are made in advance with this office. Whether or not I have insurance, I as a patient/guarantor am responsible for the charges for services rendered to the patient. I further understand that I will be responsible for any additional charges for services which may not be available at the time of leaving the office. I agree to pay for any attorney fees or collection fees that result in the pursuit of collection for services rendered. I also authorize employment verification if needed.

AUTHORIZATION TO VERIFY EMPLOYMENT

I hereby authorize Rappahannock Foot & Ankle Specialists to verify my employment if my account falls delinquent and further action is required.

DIVORCED/SEPARATED PARENTS: The parent bringing the child for treatment is responsible for any co-pay due at the time of service or balances left after insurance. We, the physician's office doesn't get involved with the financial arrangement between the parents. That is an issue that must be resolved by the two parents. Our financial policy offers you a number of payment options to choose from. You may use **CASH, CHECK, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS or CARE CREDIT.**

PAST DUE ACCOUNTS: We make every attempt to work with patients for an agreeable amount if payments need to be made on balances left from insurance, however if it becomes necessary to collect any sum of money through an attorney or collection agency, then the patient/guarantor agrees to pay any and all reasonable costs of collection, including attorney's fees, whether suit is filed or not. In the event the account is taken to court, patient/guarantor is responsible for any and all court costs incurred. Patients with delinquent accounts, cannot be seen until the office as well as the collection agency has been paid in full.

CANCELLATION, RESCHEDULING & NO-SHOW FEES

Our office enforces the following fees:

- A $50 fee will be charged for appointments that are cancelled, rescheduled with less than 24 hours' notice or missed without notice (No Show).
- If you incur one of these fees, it will need to be paid before we can schedule your next appointment.

PLEASE NOTE: PAYMENT IS EXPECTED IN FULL AT THE TIME OF SERVICE, unless insurance information or an insurance claim form is provided at the time of service. Also, upon visit you will be responsible for any co-pay/deductible/your percentage that has not been met at the time of service. Claims pending over (6) weeks will be your responsibility. Any payment received from your insurance company greater than your outstanding balance will be refunded to you or the insurance company. You are responsible for anything that is not covered by your insurance for today's visit. We bill insurances as a courtesy. If there is any information we request and feel is important for the billing process, (i.e., SSN, Physical address, etc.) and you are not willing to give this information to us you will be considered a self-pay patient and will be responsible for payment in full the date of service and to submit claim to your insurance company yourself. This also authorizes a credit report to be acquired by us if an account becomes past due.

Date: _____

Patient/Representative: _____

Relationship to Patient: _____

Signature: _____

PARACLETE
PHYSICAL THERAPY

Consent/Acknowledgement - Use and Disclosure of Protected Health Information

I understand that Paraclete Physical Therapy may use and disclose my protected health information for purposes of treatment, payment and health care operations. I also acknowledge that I have received, have been offered, or have received in the past a copy of the Practice's Notice of Privacy Practices, which provides information about how the Practice, and individuals involved in my care in the Practice, may use and disclose my protected health information. As provided in the Notice, the terms of the Notice may change. To obtain a copy of any current Notice, I understand that I can contact the Privacy Officer at (540) 735-0260.

I understand that I have the right to request that the Practice restrict how my protected health information is used or disclosed for treatment, payment or health care operations, but I also understand that the Practice is not required to agree to a requested restriction. However, if the Practice does agree, it is bound by that agreement. I understand that I have the right to revoke this consent in writing at any time, except to the extent that the Practice, or individuals involved in my care in the Practice, have already used or disclosed protected health information in reliance on my prior consent.

In order for Rappahannock Foot & Ankle Specialists/Paraclete Physical Therapy to disclose Protected Health Information to someone other than you, you must complete this authorization.

_____ _____
Name of Patient (Please Print) **Date of Birth**

May we contact you by: **Email -** Yes / No **Text:** Yes / No

I authorize Rappahannock Foot & Ankle Specialists, PLC to disclose information on my health care to the following person(s).

( ) Spouse_____
( ) Other (please identify) _____

This authorization is valid until:

( ) _____date/event ( ) One year from date I sign this form
( ) Indefinitely

Person to Call if Unable to Reach You

Name: _____
Relationship: _____ Phone #: _____

Authorized Person(s) to Speak with Regarding My Account:

( ) Spouse_____
( ) Other (please identify) _____

I have the right to revoke this form at any time by submitting a cancellation authorization in writing to Paraclete Physical Therapy.

_____ _____ _____
Patient or Legal Surrogate Date Relationship to Patient

_____ _____
Witness Date