AMPT
Advancing Movement with Physical Therapy

Last Name: _____ First Name:_____ Middle: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone:_____ Work Phone:_____

D.O.B.: _____ ☐ Male ☐ Female SSN: _____ Marital Status: _____

Referring Physician: _____ Phone: _____ Diagnosis: _____

Are you receiving Home Health Care for any reason? ☐ Yes ☐ No If yes, where: _____

Have you ever had Physical Therapy for this injury? ☐ Yes ☐ No If yes, where: _____

Is this case currently involved in litigation? ☐ Yes ☐ No If yes, Attorney Name: _____ Phone: _____

Emergency Contact: _____ Phone:_____

Name of **Policy Holder**: _____ SSN:_____ DOB: _____

Relationship to Patient: _____ Employer: _____ Address: _____

Additional Insurance Coverage? ☐ Yes ☐ No Policy Holder Name: _____ SSN: _____

DOB: _____ Relationship: _____ Employer: _____ Address: _____

Office Use Only: Type of Insurance: ☐ Private ☐ WC ☐ MC ☐ Auto ☐ Lien ☐ Cash ☐ HMO

Date Received: _____ Initial Eval Date & Time: _____ Doctor's NPI #:_____

Insurance Company Name: _____ Phone: _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Policy Number: _____ Group Number: _____ Plan Year _____

Is Pre-Cert, Auth or referral required ? ☐ Yes ☐ No Auth #: _____ # of Visits: _____ Exp _____

PCP_____ Phone #:_____ Is an RX required with claims? ☐ Yes ☐ No Fax: _____

Visit Limit: _____ Used: _____ Dollar Limit: _____ Used: _____ Modality limit:_____

In/Net DED $: _____ Amt. Met: _____ Copay: _____ Benefits: _____ /_____ out/poc _____ applied _____

Effective Date: _____/_____/_____ Date Verified: _____/_____/_____ Spoke with: _____ Time: _____

Special Instructions: _____

Secondary Insurance Company Name: _____ Phone: _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Secondary Policy Number: _____ Group Number: _____

Visit Limit: _____ Used: _____ Dollar Limit: _____ Used: _____ Modality limit:_____

In/Net DED: $ _____ Amt. Met: $ _____ Copay:$ _____ Benefits: _____/_____ out/poc _____ Applied _____

RX required with claims? ☐ Yes ☐ No Fax:_____ Plan Year _____

Effective Date: _____/_____/_____ Date Verified: _____/_____/_____ Spoke with: _____ Time: _____

Special Instructions:_____

FINANCIAL AGREEMENT/ASSIGNMENT OF BENEFITS

I understand and agree that I am totally responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I understand that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am primarily responsible for all charges regardless of my existing medical coverage. In the event that my insurance company forwards payment directly to me instead of AMPT, I will immediately deliver such payment directly to **AMPT**. Periodically, insurance companies request accident details or additional information to process your physical therapy claims; failure to provide the requested information will result in you being held responsible for the full cost of treatment. I understand and agree that if it becomes necessary to commence legal action for the collection of any outstanding charges on my account, I will be responsible for any costs and or court fees, in addition to the outstanding balance. **Note: If you have BCBS HMO, your plan requires your PCP to submit for authorization prior to treatment. It is your responsibility to obtain this from your PCP; failure to do so may result in you being held responsible for the full cost of treatment.** There will be a 1.5% late charge of any balance 90 days or over, once the insurance company pays. *Please initial* _____.

I hereby give authorization for payment of insurance benefits to be made directly to **AMPT** for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of the agreement is as valid as the original.

_____ Date _____/_____/_____

Signature *(Parent or guardian signature if patient is a minor)*

APPOINTMENT/CANCELLATION POLICY

I understand that my doctor has prescribed therapy for me, and that physical therapy is an ongoing process which requires regular attendance to be optimally effective. Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival of greater time than 15 minutes may result in a shortened treatment or cancellation. Since our primary purpose as a business is to help people, we require a 24-hour advance notice for canceling a scheduled appointment. By giving us sufficient notice when canceling an appointment, we can fill your scheduled time slot with someone else who needs our help. Failure to show for an appointment or cancellation without sufficient notice may be subject to a $25.00 charge.

Please initial _____.

CO-PAYMENT / DEDUCTIBLE AND CO-INSURANCE POLICY

Patients that carry health care insurance should remember that some policies require a co-payment for each visit or a deductible and co-insurance. Consequently, it is your responsibility, as defined by your policy, to make these payments. Additionally, you are responsible for any and all supplies, such as braces, exercise equipment, and electrodes, which are provided to you and are not covered by your particular plan. I understand and agree that I am solely responsible for all co-payments and charges incurred which are not covered under my health care plan. I also authorize the release of any medical information necessary to process this claim.

Please initial _____.

AUTHORIZATION FOR TREATMENT

I hereby consent to and authorize all therapy treatments, which in conjunction with the judgments of the attending physician, may be considered necessary or advisable for the diagnosis or treatment of the above-named patient at **AMPT**. *Please initial* _____.

CONSENT

I hereby authorize **AMPT** to provide any physical therapy services or related services as deemed necessary by the physical therapist(s). I consent and authorize **AMPT** to release all information contained in my medical and financial records, including diagnosis and test results, to:

1. any specialist involved in my care
2. my insurance company or health plan including Medicare, Medicaid
3. any person or entity responsible for paying or processing for payment of any portion of my healthcare bill(s)
4. governmental or accrediting agencies
5. any other health care provider to which I am referred or transferred for care
6. entities utilizing this information for quality management, peer review and or outcome analysis
7. any other person or entity as required or allowed by state and/or federal law

This consent applies to all records created in the course of and relating to this healthcare. To provide the practitioners who will treat me during my care with an access to my prior medical history, I also consent and authorize any health care provider to release medical information contained in my medical records from prior treatment that is relevant to my current care and treatment.

If I am the patient or the patient's legal guardian, I also consent to release billing information and medical records to the patient's primary care physician (PCP) and his/her medical group. This release shall remain valid until I notify the company, in writing, of my desire to revoke it.

Please initial _____.

CONSENT FOR TESTING

I agree that if a company employee or healthcare worker is exposed to my blood that I will grant permission to the company to have my blood drawn and to run tests for Hepatitis and/or the HIV/AIDS virus. The cost will not be my responsibility and the results will not be part of my medial record.

PERSONAL VALUABLES

I hereby release **AMPT** and its associates of responsibility for loss or damage to personal property, including but not limited to clothing, money, or other valuables kept in my possession during my care.

_____ Date _____/_____/_____

Signature *(Parent or guardian signature if patient is a minor)*

Patient Name _____

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Past Medical History

Do you currently have or have you ever had any of the following:

	Yes	No		Yes	No
Arthritis	☐	☐	High Blood Pressure	☐	☐
Asthma/ Chronic Bronchitis	☐	☐	HIV/AIDS	☐	☐
Bowel/Bladder Problems	☐	☐	Osteoporosis	☐	☐
Cancer	☐	☐	Rheumatoid Arthritis	☐	☐
Chest Pain	☐	☐	Stroke	☐	☐
Diabetes	☐	☐	Alcoholism	☐	☐
Emphysema	☐	☐	Drug Abuse	☐	☐
Epilepsy/Seizures	☐	☐	Are you currently pregnant?	☐	☐
Heart Disease/Attack	☐	☐	Do you have a pacemaker?	☐	☐
Hepatitis	☐	☐	Do you have any surgical implants?	☐	☐

Please answer <u>all</u> of the following questions (please write "none" or "N/A" if the question does not pertain to you):

Do you smoke? Yes No If yes, how many per day? _____

Do you have any current or past health or medical problems that are not listed above?_____
_____
_____

Please list all surgeries and the approximate date of the operation:_____
_____
_____
_____

Please list all medications that you are currently taking:_____
_____
_____
_____

Name:_____

Signature:_____

Date:_____

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

FOR COMPANY USE ONLY

Refusal To Sign Acknowledgement of Review of Notice of Privacy Practices

The following patient has been offered a copy of the Notice of Privacy Practices but has refused to sign the Acknowledgement of Review of Notice of Privacy Practices:

Patient: _____ Date _____

Reason (if given by patient): _____
_____
_____
_____
_____

Employee Signature: _____ Date _____

CONSENT TO PHYSICAL THERAPY EVALUATION AND TREATMENT

I, _____ the parent/legal guardian of _____, authorize physical therapy treatment to be administered by AMPT, LLC.

In the case of an emergency please contact:

_____ Phone: (_____)_____

_____ _____
Parent/Legal Guardian Date

_____ _____
Witness Date