WILLOW PHYSICAL THERAPY________________________________

2555 PHILLIPS FIELD RD, SUITE 202 FAIRBANKS, AK 99709 (907) 456-5990 PH (907) 374-8023 FAX

Name____ (circle one) **M / F** **Birth Date**______________________

Mailing Address ______________________________________ City_______________ ST____ Zip_________

Physical Address______________________________________ City________________ ST____ Zip_________

Soc. Sec. #_________________________

Employer_____________________________________ ***Work Phone***__________________

Home #_______________ Cell # ______________ Emergency contact: ______________________#__________

Appointment reminder? ___Yes ___No ___ EMAIL ___CALL HOME PHONE or ___TEXT CELL

EMAIL address: ____

Which of these influenced you to choose Willow Physical Therapy? (circle all that apply)
Internet TV Commercial Phone Book Radio Newspaper Friend/Relative Dr. Other:_____________

Date of Injury_______________ * Auto ______*in which state*? ______ * Work Comp____ * Other______

MEDICARE PATIENTS: Are you **CURRENTLY** enrolled in **HOME HEALTH CARE?** YES____ NO_____

<u>Primary Insurance Information</u>

Ins. Co Name____________________________
ID #_____________________________________

Group #_______________

Pol. Holder ____________________________
Phone#______________ ***Birth Date***____________

*Relation to Patient*_________________________

<u>*Secondary* Insurance Information</u>

Ins. Co Name ______________________________
ID #____

Group #_______________

Pol. Holder ____________________________
Phone#______________ ***Birth Date***____________

*Relation to Patient*_________________________

The following person(s) may contact Willow Physical Therapy regarding my appointments, treatment, and/or billing information :

NAME:____________________________________ *** NAME:____________________________________

RELATIONSHIP:____________________________ *** RELATIONSHIP:____________________________

SIGNATURE:____

PT_______

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PATIENT/FINANCIAL AGREEMENT

PATIENT NAME: ____________________________

Willow Physical Therapy is a licensed provider whose physical therapists develop individualized treatment plans to address your unique therapy needs. Following your initial examination, we develop a specific plan of care and will work with your primary care practitioner as needed to coordinate your care. We are pleased to serve your physical therapy needs and encourage your feedback to alert us to anything we can do to provide you the highest quality of care.

As a courtesy to you Willow Physical Therapy will bill your insurance carrier for rendered services. Each healthcare insurance payer has different guidelines for allowing coverage of physical therapy services which you as the insured are responsible to know. For example, Medicare has a limit on the amount of physical therapy services that they pay for; physical therapy treatment will continue if care is deemed medically necessary. All patients approved for physical therapy services, regardless of insurance, are responsible for any and all charges not paid for and deemed "patient responsibility" by their respective insurance carriers. Payments for deductible, co- payments and non-covered services are due on date of service.

Monthly statements, if applicable, are billed to you and payment is due upon receipt. We accept cash, personal checks, money orders, and credit cards VISA & MasterCard. There will be a $30 fee for all returned checks. Please contact Deborah Mursch in our Billing Office at 907- 456-5990 if you have questions about your bill.
ALL BALANCES DUE PAST 90 DAYS WILL BE TURNED OVER TO CORNERSTONE CREDIT SERVICES

Patients Filing to no Insurance - Cash Patient Financial Agreement

Charges are as follows 1 hour visit = $200.00 each, ¾ hour visit = $150.00 each, ½ hour visit = $100.00 each

Full payment will be expected to be paid on the date of services. Initial (if applicable) ________

Should you or your caregiver experience a situation that requires the attention and resolution of a Manager, please contact our practice either by phone or in writing. Our Manager will interact with you to reach a resolution of any identified situation where our quality of service has been compromised. We use such situations to alert us to improvements we can make to better serve all of our patients.

I was given the opportunity to receive a Willow Physical Therapy HIPAA Privacy Statement. **Initial**________

PATIENT FINANCIAL STATEMENT OF AGREEMENT

1. My signature below signifies that I have read and understand this Financial Agreement for Willow Physical Therapy to provide me physical therapy services. I agree to the terms in this patient agreement and agree to comply. I understand that if I fail to follow the terms of this agreement, I could be discharged from service.
2. I authorize the release of any medical information necessary to process my insurance claims.
3. I authorize any payments of medical benefits to be paid directly to Willow Physical Therapy.

Signature of Patient or Personal Representative (Or Witness if signature is by mark) **Date**

____ __________

WILLOW PHYSICAL THERAPY______________________________

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No-Show / Same-day Cancellation Policy

At Willow Physical Therapy, we expect you to get the most out of your physical therapy visits. Your physical therapist will provide you with your plan for care during the evaluation appointment and will inform you of the required number of visits to help you meet your goals. A recent study has shown that patients who adhere to their physical therapy plan of care increase their ability to have success from physical therapy by 93%.

Even one missed visit can significantly decrease your success and result in a more chronic problem. We strongly stress the importance of keeping all scheduled appointments to achieve your personal physical therapy goals.

Our schedule is very full and certain time slots are not always available for patients who need them. For this reason, we expect at least 1 days' notice if you cannot attend an appointment; for any reason. If you cannot make a scheduled appointment, for any reason, we require a day's notice of the cancellation. When you call we will assist you in rescheduling this appointment because getting you results is our main goal.

Please read our policy and sign at the bottom indicating you understand our same-day cancellation / no-show policy.

1. As experts, we know that you will not get better if you do not attend your appointment. When you call to cancel an appointment, we expect that you will have other times available so we can reschedule you right away.
2. We require that you cancel any appointment that you cannot make with no less than 24 hours' notice.
3. We will reschedule you at that time to make sure you continue with your plan of care.
4. While we understand that illness can strike at anytime, repeated cancellations for illness without 24 hours' notice will not be an accepted excuse for untimely notice.
5. For all appointments, we expect that you will **arrive on time**, dressed for your session, and ready to begin at your scheduled treatment time.
6. While traffic can be unpredictable, we expect that you will call us immediately if you are running late for your scheduled appointment, so we can be prepared for your late arrival.
7. Please also be aware that if you are late for your appointment, you are missing the time that we have specifically scheduled for your care and we cannot guarantee that we will be able to provide you with your full treatment as we have reserved the appointment time following yours for someone else. Chronically late patients will be asked to change their appointment times.
8. Please note: when you need to change or cancel an appointment, we need 24 hours' notice so we have enough time to refill that spot with someone else who needs that appointment time. Same-day cancellations or no-shows are not permitted and there is a **$50.00 if you do not provide at least a days' notice of your appointment change or cancellation. This is your responsibility as insurance will not cover it.** To avoid the late notice fee, call our office **during business hours** and at least a day in advance for any appointment changes or cancellations. This will allow us to reschedule you for another time and help other patients get the care they need by offering that appointment time.

Thank you for reviewing this policy. Please sign and return the signed copy and keep the second copy for your records.
We look forward to working with you to meet your physical therapy goals.

Aisha Wilbur, Owner

I have read this policy and by signing below I am indicating that I understand and will adhere to this policy.

_______________________________ _______________________________ _______________

Patient Signature Patient Name Date

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Patient's History of Current Condition or Injury

Name: ____ **Today's Date**: ____________________

Age: _____ **Date of Birth**: ____________ Sex: _____ **Marital Status** ______ # **Children** _____ **Ages**____________

Occupation: _______________________________________ **R- handed** ____ **L-handed**____ **Ht.**______ Wt. _____

Please describe your main problem: ____

When did your symptoms start? __________ **Can you identify a cause**? ____________________________________

Describe your symptoms. (What does it feel like…sharp, dull, achy, dizzy, nauseated etc) _______________________

____

____

____

Are your symptoms getting- Better Worse Same **Have you ever had similar symptoms in the past?** No _ Yes_

What activities/positions make your symptoms worse? ____

What activities/positions make your symptoms better? ____

____

Pain rating: Indicate your LEVEL OF PAIN **WITH ACTIVITY** by circling the appropriate number on the scale below:

0	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*
No Pain	*Mild Pain*				*Moderate Pain*		*Severe Pain*			*Worst Possible*

Rate pain 0-10
Pain at BEST ___________
Pain at WORST __________
CURRENT Pain __________

If you experience pain, is it there all the time (constant)? Yes _____ No _____

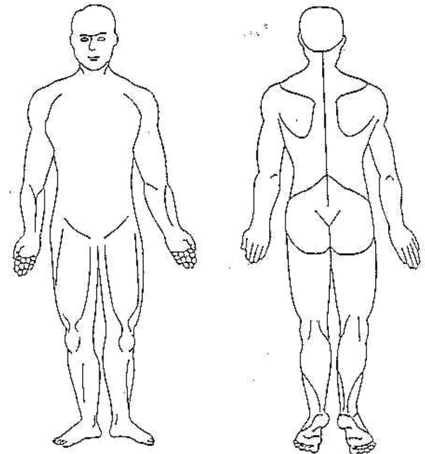
Does the pain move or radiate anywhere? No _____ Yes, Describe

____

Do you have numbness, tingling, or weakness? No _____ Yes, Describe

____

Mark area of pain, numbness or tingling on body diagram



Have you had any special tests to evaluate your current problem? (X-ray, MRI, CT scan, Etc.) ________________________

____

Patient's Name: ____ **Date:** ______________________

Have you had any changes in your bowel, bladder or sexual function as a result of your symptoms? No ____ Yes, Describe ____

Have you been discharged from the hospital, a skilled nursing facility, or Home Health Agency in the past 30 days related to this condition? Yes ___ No ____ If yes, please describe: _____________________________________

Please mark those treatments listed below that have been tried or currently trying:

___Physical Therapy ___Chiropractic ___Acupuncture ___Braces ___Collars ___Tens Unit ___Injections
___Medications ___Massage Therapy Other (please describe):____

Past Medical History (Is there anything else that may affect your care, i.e., history of cancer, diabetes, heart attack, fractures**, or** surgical procedures?)

____

____

Medication Record:

Please list all current medications, with dosages (Include prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements).
If you already have a list (including dosage amounts) please check here and provide a copy of the list to your therapist at the time of your evaluation ___________ (Patient initials)

Current Medications:	Dosage (units or mg)	Frequency (times per day)	Administrated route (oral, injection, topical, etc.)	Reason for taking medication

Use additional sheet if more space is needed

Job Description/Social Activities: (physical tasks, amount of sitting, lifting, computer work etc.): ______________

____

What are your functional goals for your course of physical therapy? ____

____

At the present time, would you say your health is excellent, very good, fair, or poor? _________________________

____ ______________________
Patient Signature Date