5 STAR PHYSICAL THERAPY SPECIALISTS
13060 US HIGHWAY 27 SUITE C4
DEWITT, MI 48820
PHONE: 517-668-6561
FAX: 517-306-2372
E-MAIL: OFFICE@5STARPT.COM
WEBSITE: 5STARPT.COM

PATIENT INTAKE AND CONSENT FORM

TODAY'S DATE_____

NAME (FIRST, MIDDLE INITIAL, LAST)_____ DOB_____

ADDRESS_____CITY_____STATE_____ZIP_____

HOME PHONE_____CELL PHONE_____EMAIL_____

DATE OF INJURY/ONSET_____ ACCIDENT RELATED?: YES / NO IF YES: AUTO / WORK / OTHER

RESPONSIBLE PARTY_____CASE MANAGER_____PHONE NUMBER_____

EMPLOYER_____OCCUPATION_____

ADDRESS_____CITY_____STATE_____ZIP_____

PRIMARY INSURANCE_____INSURED NAME_____

ADDRESS_____CITY_____STATE_____ZIP_____

INSURED DATE OF BIRTH_____INSURED SEX/GENDER: M / F RELATIONSHIP TO INSURED_____

GROUP #_____ID#_____INSURED EMPLOYER_____

SECONDARY INSURANCE_____ INSURED NAME_____

ADDRESS_____CITY_____STATE_____ZIP_____

INSURED DATE OF BIRTH_____INSURED SEX/GENDER: M / F RELATIONSHIP TO INSURED_____

GROUP #_____ID#_____INSURED EMPLOYER_____

EMERGENCY CONTACT_____DAYTIME PHONE NUMBER_____

ARE YOU RECEIVING OR HAVE YOU RECEIVED HOME HEALTH SERVICES, OR OTHER THERAPY SERVICES? YES / NO

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MEDICAL HISTORY FORM

PATIENT NAME_____REFERRING PHYSICIAN_____

DATE OF INJURY_____CAUSE OF INJURY_____

WHAT ARE YOU NOT DOING NOW BECAUSE OF YOUR INJURY OR CONDITION?

_____

WHAT ARE YOUR GOALS OR WHAT DO WANT TO BE ABLE TO DO THAT YOU CANNOT DO NOW?

_____

DESCRIBE YOUR GENERAL HEALTH (CIRCLE ONE) EXCELLENT GOOD FAIR POOR

DID YOU HAVE RECENT SURGERY OR HOSPITALIZATION? (CIRCLE ONE) Y / N IF YES: WHEN AND WHY?

_____

HAVE YOU HAD PHYSICAL OR OCCUPATIONAL THERAPY THIS YEAR? (CIRCLE ONE) Y / N

HAVE YOU HAD ANY RECENT IMAGING FOR THIS CONDITION? (X-RAY, MRI, CT SCAN) (CIRCLE ONE) Y / N

IF YES, WHAT WERE THE RESULTS IF KNOWN?_____

PLEASE LIST PERTINENT MEDICAL HISTORY (HEART AND LUNG PROBLEMS, HIGH BLOOD PRESSURE, DIABETES, AUTOIMMUNE CONDITIONS, ARTHRITIS, CANCER, PRIOR SURGERIES, ETC)

_____

_____

PLEASE LIST CURRENT MEDICATIONS OR PROVIDE A LIST FOR OUR REFERENCE_____

_____

PLEASE DESCRIBE ANY OTHER MEDICAL CONCERNS YOU MAY HAVE_____

_____

SIGNATURE OF PATIENT:_____DATE_____

REVIEWED BY PHYSICAL THERAPIST:_____

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***PLEASE INITIAL EACH SECTION OF THIS FORM WHERE APPLICABLE**

CONSENT TO TREATMENT: I consent to physical therapy and related services at 5 Star Physical Therapy Specialists. I understand and agree that such physical therapy and related services may involve bodily contact including the use of "hands on" examination and treatment procedures that can be sensitive in nature.

*_____

TREATMENT OF MINORS: I, as a parent/guardian of a minor receiving physical therapy treatment do agree and understand that I have been advised to remain on the premises during physical therapy treatment, and waive any claim I may have resulting from failure to do so. *_____

LIABILITY: I know and agree that 5 Star Physical Therapy Specialists is not responsible for lost or damage to personal valuables. *_____

WAIVER AND RELEASE: I hereby release 5 Star Physical Therapy Specialists and its employees of any and all liability, claim, damage, or loss of any kind due to my refusal to accept emergency medical services including but not limited to ambulance/urgent care service, physician services, and emergent medical attention. *_____

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the service I receive, I will be financially responsible for payment.

*_____

ATTENDANCE POLICY: I understand I may be charged a cancellation or no-show fee of $50 for missed visits if I do not provide notice at least 24 hours in advance, if there are multiple occurrences. I understand if 3 no-shows occur, I may be discharged from physical therapy prior to completion of the plan of care.

*_____

NOTICE OF PRIVACY PRACTICE: I acknowledge receipt of Notice of Privacy Practices *_____
I certify that all of the information provided is true and correct

Patient/Guardian Signature _____

Date: _____

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Patient Financial Policies

We feel the best patient experiences come from great care and service, and this includes having up-front knowledge and expectation of what physical therapy might cost you. As a courtesy, we will attempt to verify your physical therapy insurance coverage and benefits prior to your first scheduled visit. There may be times in which verifying insurance benefits prior to your initial evaluation is not possible due to timing constraints or inability to verify your benefits with your insurance provider. The information verified may be subject to errors due to mis-information provided by the insurance provider and according to your insurance provider, this is not a guarantee of payment.

Our Policy on Timing of Collections

Co-pays – Payment is expected on the date of service, prior to seeing the physical therapist

Co-insurance – Payment is expected once we have received the co-insurance amounts from your insurance provider. Our receptionists will notify you of any balances as they come in.

Deductible – A **down payment of $100 for eval and $65 per each regular visit** is required on the date of service, prior to seeing the physical therapist. This is a down payment and is the minimum amount that could be owed when physical therapy is a deductible service on any commercial insurance plan. Please note; this will not necessarily be your full payment depending on the type of insurance and plan you hold, there may be additional balances owed per visit once insurance has processed your claims. These additional balances are expected to be paid once we have received final amounts from your insurance provider. Our receptionists will notify you of any balances as they come in and they would also be happy to print statements for your reference.

Our Policy on Insurance Denials

If your insurance provider denies visits for any reason or you reach a maximum number of PT visits for the year, you will be expected to pay the non-insured rate of $100 per evaluation or $65 per each return visit. This also applies if we are not notified of an insurance plan change – any visits that cannot be collected by the new plan or insurance provider will also be expected to be paid at the non-insured rate as listed above.

Failure to make payments as described in this policy may lead to a suspension in future physical therapy visits until a payment can be made. Please know if there is a financial burden preventing you from being able to comply with these collection policies, we would be happy to work with you on a payment plan. Please let us know if you have any questions at any point regarding insurance details or payments.

Thank you,
5 Star Physical Therapy Specialists

I acknowledge that I, the patient (or legal guardian of the patient) understand and agree to the above information and policies. I agree to notify 5 Star Physical Therapy Specialists immediately with any changes to my insurance plan or provider.

X_____ _____

Signature of Patient or Legal Guardian Patient Printed Name

_____

Date

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Plan Details

Below are your insurance plan details for Physical Therapy services as provided by your insurance company. Again, we strive to give the best, most accurate information; however, there may be times your insurance provider processes claims differently than the information we are given ahead of time. Health insurance is a contract between you and the insurance provider and you will be required to pay amounts owed as determined by your insurance provider even if they differ from information we have received and provided for you below.

As an additional courtesy, we provide an estimated dollar range to be expected if deductible or co-insurance applies with your plan. These estimates are based on current and past experiences with each insurance carrier and the amounts can vary widely by specific plans within an insurance carrier, new coding rates (set by insurance carrier), etc. Please note these are again rough estimates and actual amounts owed may be more or less than the approximate ranges provided.

Primary Insurance Provider_____

Deductible_____

Co-insurance_____ **Co-pay**_____

Maximum Out of Pocket_____

Maximum # of Therapy visits per year _____ (please note: most insurances have physical therapy as a combined benefit with occupational and speech therapy as well. Also, if you have received **chiropractic care** you may want to verify with your insurance company the number of visits remaining per year as some chiropractors will bill claims using physical therapy coding.

It is important to let us know if you have had other physical, occupational, or speech therapy within your insurance plans' fiscal year so we can work to make sure you do not go over that limit without prior knowledge.

Thank you for trusting us with your care. We look forward to working with you!!