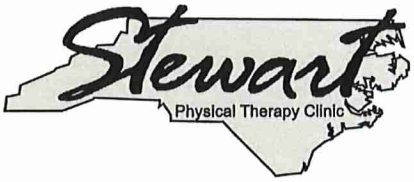

Eval Date: _____

PATIENT REGISTRATION

Patient Information

Patient Full Name:_____ SS#/DL#:_____

Mailing Address:_____ City/State/Zip:_____

Home Phone #:_____ Cell Phone #:_____Age:_____ Date of Birth:____/____/____

Would you like to receive an automatic appointment reminder? Yes / No If yes, circle one: Text or Email

Email Address: _____ Marital Status: M D W S

Emergency Contact: _____ Phone: _____ Relationship_____

Accident / Injury Information

How did you find out about Stewart Physical Therapy: _____

Reason for therapy: _____ Onset / Accident or Surgery Date:_____

Number of chiropractic visits, physical, speech, or occupational therapy this insurance plan year? _____

Referring Doctor & Practice Name: _____ Primary Care Physician: _____

Was this an injury at work? Yes / No If Yes, **Name/Phone # of Case Manager:** _____/_____

Employer Name (if work related injury):_____ Currently Working: Full Time / Part Time / On leave

Is this injury due to an auto accident or other accident in which someone else is at fault: _____

If yes, what state did the accident occur? _____

Insurance Information

Primary Insurance: _____ Policy #: _____

Secondary Insurance:; _____ Policy #: _____

Medicare Patients

Have you received physical, speech, or occupational therapy services this year?_____

Are you currently receiving (or recently completed) any Home Health Care? ____If Yes, when was it completed:_____

If patient is a minor, please provide the following responsible party information:

Responsible Party Name: _____Date of Birth: ____/____/____ Phone#: _____

Relationship to Patient: _____ Address: _____

MEDICAL INFORMATION

Patient Name:_____ Next Doctor's Appt:_____

Reason for Therapy:_____Onset/Accident or Surgery Date: _____/_____/_____

Are you diabetic? Yes / No If yes, do you take insulin? Yes / No

Have you ever had surgery? Yes / No

If yes, please list:

Date	Description	Date	Description

Do you suffer from dizziness, fainting, seizures, or convulsions? Yes / No

If yes, please explain_____

Do you have high blood pressure? Yes / No

If yes , please explain_____

Do you have a heart condition? Yes / No Please list: _____

Do you have a pacemaker? Yes / No

Have you ever had a blood clot or phlebitis? Yes / No

If yes, where and when _____

Are you currently or have you in the past received treatment for cancer? Yes / No

If yes, when_____

Do you have any other health problems? Yes / No

If yes, please describe_____

Are you or could you be pregnant? Yes / No

Patient or Legal Guardian Signature: _____ Date: _____/_____/_____

Stewart Physical Therapy Clinic

Patient Name _____

Date _____

Current Medications List (Prescription, non-prescription, vitamins, herbals)

Medication	Dosage	Frequency	Reason

Known Allergies:

STEWART PHYSICAL THERAPY CONSENT FORM

CONSENT TO TREAT

I hereby consent to evaluation and/or treatment of my condition by a licensed physical or occupational therapist employed by or under contract with Stewart Physical Therapy. I understand that I will be informed of the nature and purpose of the procedures, evaluation, and plan of treatment. I will also be informed of the expected benefits and possible complications or discomfort, which may result from skilled physical therapy care.

I understand that there is not a guarantee that the proposed course of treatment will improve my condition and that it is possible, although unlikely, that the course of treatment may cause additional pain/discomfort or aggravate my condition. I understand I will be given the opportunity to discuss my condition with the treating therapist. I consent and authorize Stewart Physical Therapy Clinics, Inc (including students in training) to administer treatment under the direction and supervision of the physical or occupational therapist. **Initials**_____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize Stewart Physical Therapy to release medical information necessary to process insurance claim(s) on my behalf for services rendered. I request payment of any medical insurance, auto insurance, or liability proceeds or settlements to be made directly to Stewart Physical Therapy. I understand that I am responsible for any balance remaining after insurance or settlement from all sources. I agree to pay any remaining balance within 30 days. If I fail to pay any remaining balance due, Stewart Physical Therapy will have the right, to the extent allowed by law, to be paid back by me for all costs and expenses incurred in collecting sums due and in enforcing my agreement to pay, including but not limited to, reasonable attorney's fees. **Initials**_____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION NOTICE OF PRIVACY PRACTICES

I have read the Stewart Physical Therapy Patient Consent for Use and Disclosure of Protected Health Information/Notice of Privacy Practices. I acknowledge receiving a copy and understand that at any time I may ask questions concerning my privacy rights and how Stewart Physical Therapy may use and disclose my protected health information. **Initials**_____

ACKNOWLEDGMENT OF RECEIPT OF FINANCIAL POLICY

I have read and received a copy of the Financial Policy and understand Stewart Physical Therapy has not guaranteed payment by my insurance company only quoted what was relayed to them by my insurance company. In addition, I understand that any check received may be deposited electronically and a $30 fee will be added to my bill for any returned check. **Initials**_____

CANCELLATION/NO SHOW

During your evaluation, you and your therapist will establish goals for your recovery. These goals are based on your participation in your therapy appointments. If you must cancel your scheduled appointment, we request a 24 hour notice. We reserve the right to charge you a $25 cancellation/no show fee if you habitually cancel or no show to your scheduled appointments. **Initials**_____

EMERGENCY PREPAREDNESS

Stewart Physical Therapy staff have made me aware of the Evacuation Plans and Procedures in the event of an emergency. **Initials**_____

_____

Patient/Legal Guardian Signature **Date**

_____

Patient Name

AUTHORIZATION TO DISCUSS PROTECTED HEALTH INFORMATION (PHI)

Name: _____ Date of Birth: ____/____/____

PLEASE CHOOSE ONE OF THE OPTIONS BELOW

- o I DO NOT give permission for my protected health information (PHI) to be discussed with anyone other than myself.
- o I DO give Stewart Physical Therapy authorization to discuss my protected health information (PHI) with the individual(s) I have indicated below:

Name	Relationship	DOB	Appointments	Financials	Medical Records
			Yes / No	Yes / No	Yes / No
			Yes / No	Yes / No	Yes / No
			Yes / No	Yes / No	Yes / No

Rights of the Patient:

- I have the right to revoke this authorization at any time by contacting our office.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization shall be in force and effect until revoked by the patient or patient representative.

_____ _____

Patient / Authorized Representative Signature Date

Stewart Physical Therapy Clinic, Inc. Financial Policy

Thank you for choosing Stewart Physical Therapy Clinic, Inc. for your rehabilitation needs. We are committed to providing you with the best possible medical care. We want to assist you in understanding your financial responsibility for your care. The following information outlines your responsibility in relation to payment for your therapy services.

We have contracts with most major health plans. As a courtesy to you, we will verify your outpatient physical therapy benefits with your insurance company. This verification is not a guarantee of payment, we quote to you information relayed to us by your insurance company. Stewart Physical Therapy cannot be held liable for any error or misinformation of quoted insurance coverage or benefits. Insurance companies determine if charges will be covered when they receive an insurance claim, on occasion insurance companies do process claims differently than initially quoted. In these cases, patients are always responsible for the amount indicated on the explanation of benefits after the claim has processed.
We encourage you to contact your insurance to verify benefits. When doing so ask for outpatient physical or occupational therapy benefits in an office setting. This will help you become more familiar with your benefits for therapy.

Our contract with your insurance company requires that we collect patient responsibility at the time of service. You may have a copay, coinsurance, or deductible that needs to be met. Please be prepared to pay this every visit. In the event that a patient continually does not pay their responsibility, we may need to discontinue therapy until the patient financial responsibility has been resolved.

We are contracted with BCBS of North Carolina, however, there are some BCBS policies that have a more limited network such as: Blue Value, Blue Home, Blue Local, and Blue High Performance. These plans are exclusive to Atrium Health, Wake Forest, Duke Health & Wake Med, or UNC Healthcare. We are contracted with Aetna, however Duke Select and Duke Basic Custom Duke plans are limited to Duke Providers. Since Stewart Physical Therapy is a private practice, we are not considered in network for these plans. As a courtesy to you and your physician, we will treat you for your in network benefit. This may include a copay, coinsurance, or deductible. Please note, any claims filed on your behalf will be applied to your out of network deductible and out of pocket, not in network. Since these are out of network, the out of pocket in network benefit does not apply. If you reach your in network out of pocket, you will still be responsible for your copay or coinsurance.

If you have been involved in an accident, we will gladly provide your attorney or any third party insurance with information necessary to resolve your claim. However, Stewart Physical Therapy cannot wait until your claim settles for payment. You may file your personal health insurance, pay the self pay rate, establish a payment plan, or have your attorney or third party insurance pay us on a claim by claim basis.

There are circumstances in which patients do not have insurance coverage, have exhausted their physical therapy benefits, or choose not to file with their medical insurance. In those cases, we do offer patients a discounted self pay rate. We are able to offer this discounted rate due to fees we do not incur when filing claims or mailing statements. The self pay rate for an evaluation is $160 and subsequent visits will not exceed $75 per visit. This amount must be paid each day when services are rendered, **no exceptions**. Payment plans are not permitted on discounted self pay rates. In addition, the codes used are not AMA CPT codes, they are internal codes that are not recognized by insurance companies. If you are going to submit a statement to a third party for reimbursement, the self pay option is not advisable since the codes used will not be recognized by any insurance company.