FOOTHILLS
Physical Therapy

CONSENT FOR TREATMENT

I authorize the staff at Foothills Physical Therapy to undertake such treatment and procedures as deemed appropriate to improve my condition. It is recognized that the practice of medicine is not an exact science and, as such, no guarantees are made by the staff of Foothills Physical Therapy as to the results of treatment or interventions performed. I am advised that I have the full right to a full explanation of any treatment or procedure utilized. I understand that I have the right to refuse treatment; but, in doing so, I also understand that the desired outcome of my treatment program may be affected. Persistent refusal to participate or cooperate in the recommended treatment program may result in my discharge from the program.

Personal Property: It is understood that Foothills Physical Therapy shall not be liable for loss or damage to any personal items brought to Foothills Physical Therapy during your course of treatment.

Notice of Privacy Practices: I hereby acknowledge that I have received a copy of Foothills Physical Therapy's Notice of Privacy Practices on this day.

_____ _____ _____

Patient Signature | Printed Name | Date

HIPAA RELEASE OF INFORMATION

Privacy regulations require us to have a release signed by our patients so we may speak with family members, friends and other relations regarding your medical treatment and patient financial information. Each person you wish to be considered a contact must be listed individually by name (including a Spouse or Significant Other).

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

Patient/Guardian Signature _____ Date_____

CANCELLATION / NO SHOW POLICY

Foothills Physical Therapy is founded upon, one-on-one, quality care. We are dedicated to providing an empowering environment with individualized care to achieve optimal healing and functional recovery for our patients. In keeping with our mission, we ask that our patient be adherent to their scheduled physical therapy appointments.

In order to be respectful of other patients, ***all patients*** are required to give at **least a 24 hours** advanced notice when canceling or rescheduling an appointment. Failure to give a 24-hour notice will result in a missed appointment fee of $75.

- One warning will be given for your first late cancel. No shows will not be given a courtesy warning.
- We do have the right to charge you a **$75.00 fee.** If you are charged a $75.00 fee you are required to pay that fee prior to your next appointment.
- After 3 missed appointments your therapist may discharge you from care
- Showing late to an appointment will result in less treatment time. Showing 15 minutes late to an appointment may result into rescheduling the appointment.

Patient/Guardian Signature _____ Date_____

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FINANCIAL POLICY

Insurance

Your insurance coverage is a contract between you and the insurance company, and we are not a party to that contract. It is your responsibility to know your insurance benefits including referrals, pre-certifications and required authorizations. We will submit your claims to your primary and secondary insurance companies however we do expect payment for all services within 90 days. It may become necessary for you to pay your account in full if your insurance fails to do so within 90 days. **If we are given incorrect or incomplete insurance information / insurance card you will be billed and payment will be expected within 90 days, unless the issue is resolved.**

Accident Claims

We will need the claim/case number and carrier/adjuster's name prior to the first visit to obtain prior authorization for treatment.

- Motor Vehicle Accident (MVA): **We do not accept 3rd party payers.** We will bill the patient's personal motor vehicle insurance with med pay. If med pay is unavailable the patient is required to pay out of pocket or bill their personal health insurance.
- Worker's Compensation: Your works compensation carrier will approve physical therapy and pay for services that they determine are pertinent to your rehabilitation regarding your work comp injury. If at any time your works compensation carrier determines that a service that is being provided is not reasonable and necessary and subsequently denies payment for a particular service performed by Foothills Physical Therapy, the patient will be held responsible for payment.

Patient Responsibility & Payment

Payment of copays and deductibles will be due at time of service. We ***estimate*** the patient will be left with $120-$150 per visit while meeting their deductible. If the patient's deductible has not been met, **we require a deposit of $120 to $150 per visit until deductible has been satisfied**. Any underpayment will result in a balance and be billed to the patient. Any overpayment will be refunded to the patient at the end of treatment. Failure to pay these amounts may be a violation of our contract with your insurance company. **You are ultimately responsible if your insurance denies a claim for any reason.** The amount of your bill is expected to be paid in full within 30 days of the date on the statement. Anything over 30 days is considered past due.

Supplies: Do not get billed to the patients health insurance. The patient will be responsible for all supply costs at time of service.

Modalities: Based on the plan of care and insurance plan additional services such as estim, vaso, hot/cold packs, ionto, ultrasound, dry needling, and traction may be an additional cost of up to $20 that the patient will be responsible for. Please discuss these additional services with your provider before treatment.

Payment Options

We understand that financial circumstances vary from patient to patient. If you are unable to pay your due balance in full you must call the office at 208-343-4700 opt 5 to make payment arrangements. To stay in good standing a ***reasonable*** agreement must be established with the office. If a patient's balance has reached $1,000 treatment will be stopped unless otherwise directed by the treating therapist.

Our office accepts the following payment methods: cash, personal checks, VISA, MasterCard, Discover, and American Express credit cards.

Non-Payment

Failure to pay will result in your account being referred to a collection agency, which will affect your credit. NSF checks will result in a $20.00 returned check fee.

I have received this financial policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts will be referred to a collection agency.

_____	_____	_____
Patient Signature	Printed Name	Date

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CREDIT CARD ON FILE

****Please sign only if you would like to keep your credit card on file****

The below listed Merchant's card payment software allows for the secure storage of credit card information, through tokenization, for future payments associated with Merchant's health care practice. You authorize charges to your credit card by Merchant as payment for all products, services, fees and charges under your account with Merchant. A receipt for each payment will be provided to you if requested and the charge will appear on your credit card statement. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Merchant in writing of any changes in my account information or termination of this authorization. I acknowledge that the origination of credit card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card.

Merchant Information
Address: 1673 W Shoreline Dr STE 230 Boise, ID 83702
Phone #: 208.343.4700 opt 5
Email: ariana@foothillspt.com

Customer Card Details
☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name: _____

Card Number Ending in: _____ **(Last 4 digits only)**

(Full card data, expiration date, and CVV will be captured on initial transaction and retained for future use)

Cardholder Signature _____ Date _____

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Patient Intake

Referring Physician if applicable: _____

How did you hear about us?

Friends & Family	Social Media	Internet/Website	Community Outreach	Other

Patient Name (First/Last): _____

Nicknames/Preferred Name: _____

D.O.B: _____ Age: _____ Gender: Male/Female/Other

SSN: _____ Email Address: _____

Home Address: _____ City: _____

State: _____ Zip Code: _____ Marital Status: Married/Single /Divorced/Widowed

Preferred contact method for appointment reminders: **Text Message Voice Call Email**

Primary Phone: _____ (Home, Work, Cell)

Secondary Phone (If applies): _____ (Home, Work, Cell)

Emergency Contact Name: _____ Phone: _____

Employer: _____ Phone: _____

Employer Address: _____

*****Are you currently receiving ANY home health related services? Yes/No*****

*****Have you received ANY home health related services this year? Yes/No*****

If yes, discharged date? _____ How many Visits: _____

Continue to Back

(Please be aware attending Home Health or another Physical Therapy/Chiropractic office may count towards your insurances visit maximum. You must be discharged from Home Health before the date of your first visit with us.

Insurance Policy Holder Information:

Policy Holder Name: _____

D.O.B: _____ SSN: _____ Gender: Male/Female

Relation to patient: Self Spouse Parent Other

Address: _____City: _____ State: _____

Zip Code: _____Primary Phone: _____ (Home, Work Cell)

Employer: _____ Phone: _____

Employer Address: _____

Guarantor Information (Person Responsible for the Bill):

****Anyone under the age of 18 must have a guardian/parent on file****

Name (First/Last): _____

D.O.B: _____ SSN: _____ Gender: Male/Female

Address: _____ City: _____ State: _____

Zip Code: _____ Primary Phone: _____ (Home, Work, Cell)

Employer: _____ Phone: _____

Employer Address: _____

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PATIENT HISTORY FORM

Name: _____ D.O.B _____ Age: _____

*****Have you received or currently in Home Health or Physical Therapy? YES NO**
If Yes, what was the date range?_____ How many visits? _____
(Please be aware Home Health or attending another Physical Therapy office may count towards your visit maximum.)

Current Conditions/Chief Complaint: _____

_____

When did the problem begin? _____

What happened? _____

_____

Have you ever had this problem before? If yes, explain. _____

_____

What aggravates or makes your problem worse? _____

_____

What eases or makes your problem better? _____

_____

What are you currently doing to make your problem better? _____

_____

What are your goals for physical therapy? _____

_____

Functionally, what are you having difficulty with?
(For example: driving, walking, prolonged sitting, lifting, working….) _____

_____

Current Medication (please list all): _____

_____

Are you allergic to any medications? (please list all): _____

_____

(Complete on back)

Medical History: _____

_____

_____

Surgical History: _____

_____

_____

Are you experiencing any of the following?

Fever/chills/sweats	**Y**	**N**
Nausea/vomiting	**Y**	**N**
Dyspnea (difficulty breathing)	**Y**	**N**
Syncope/dizziness	**Y**	**N**
Recent onset of weakness	**Y**	**N**
Recent change in bowel or bladder control	**Y**	**N**

Functional / Social Questions:

Are you currently working? **Y N**

Full duty, no limitations? **Y N**

If not working, how long have you been out of work?

_____

-Difficulty with self-care? **Y N**

-Difficulty with home management (shopping, care of dependents, chores, etc.)? **Y N**

-Difficulty with work activities? **Y N**

With whom do you live? (circle one)
Alone Spouse Group setting Caregiver, Child(ren) Other_____

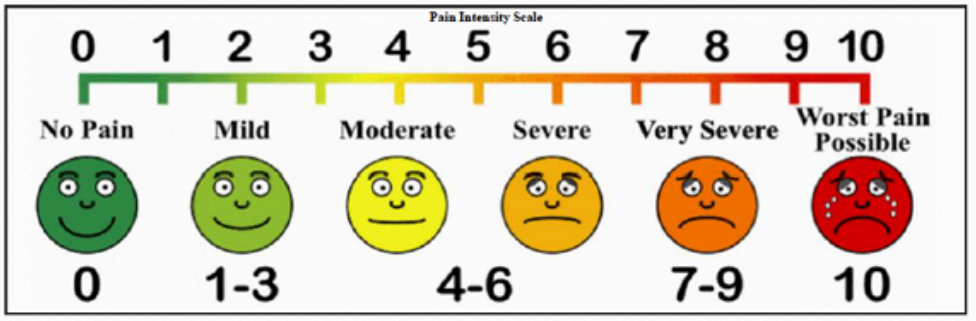
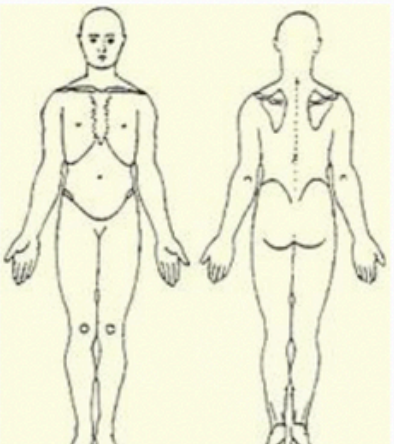
- Do you feel you need social services/counseling for any of these concerns? **Y N**

Have you undergone any diagnostic testing for this problem (x-rays, MRI, CT Scan, EMG, etc.)?

_____

Please refer to the Pain Intensity Scale to rate your pain in the boxes below.

At Best ☐ **At Worst** ☐ **Average** ☐ **At This Moment** ☐



Please mark on the body chart the site(s) of pain for which you are seeking physical therapy.