The Physical EDGE

Performance-Driven Physical Therapy & Fitness

Financial Policy

Thank you for choosing The Physical Edge as your physical therapy provider. We are committed to your treatment being successful. Please understand that payment of your bill is a considered part of your treatment. The following is a statement of our *Financial Policy* that we require you to read and sign prior to treatment.

All patients must also complete our information and insurance form before seeing a therapist.

Insurance

We will gladly bill your insurance company if you have provided us with all the necessary information to do so, on a weekly basis. Your contract for health insurance is between you and your insurance company. We are not a party to that contract. It is ultimately your responsibility to see that your physical therapy bill is paid in full. Agreements with your insurance companies vary greatly and it is your responsibility to know what your insurance company covers and what portion you are responsible for. Any remaining balance unpaid by your insurance company will be your responsibility to pay in a timely manner. We assume no liability for errors made by your insurance company for this quotation. In the event a check is returned for any reason, a $25.00 charge will be made to your account.

The above does not apply to patients who are covered by workers compensation. However, if Worker's Compensation denies benefits, you may be held responsible for the total amount of charges for services rendered.

We cannot legally charge for services less than the rates established by Medicare. A copy of the Medicare fee schedule can be provided upon request.

Co-payments, Co- insurances and deductibles will be due at the time of service.

Estimated Patient payment/co-payment/Co-insurance/deductible amount per visit $_____

If you have questions about your charges for physical therapy services please contact our billing dept (888) 550-2112 X1061

Cancellation and No-Show Policy

Because we commonly have a waiting list, unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments. **The charge for a cancelled or missed appointment without proper notice is $40.00.** This charge does not go through insurance but is the patient personal responsibility. This charge must be paid prior to receiving any additional treatment.

Patient Guardian/Responsible Party:_____Date:_____

The Physical Edge Representative:_____Date:_____

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Appointment Agreement

If an appointment is not cancelled at least 24 hours in advance, our policy is to charge for missed appointments. **The charge for a cancelled or missed appointment without proper notice is $40.00.** This charge does not go through insurance and is your responsibility to pay before receiving any additional treatment.

Repeated tardiness or not showing for scheduled appointments will result in your future appointments being cancelled; if you are a Workers Compensation patient your nurse case manager and physician will be notified.

_____ _____

Patient Guardian/Responsible Party Signature Date

_____

Patient Guardian/Responsible Party Print Name

Consent for Treatment

Consent for Physical Therapy: Knowing that I am suffering from a condition requiring a diagnostic or medical treatment, I hereby consent to care by The Physical Edge thereafter to be known in this document as "Clinic", as they may seem necessary by their judgment, under the prescription of a licensed physician. I do hereby voluntarily consent to the rendering of care for a condition requiring physical therapy services. I understand and expect that the care I receive by the Clinic will meet customary standards, I do understand that medicine is not an exact science and acknowledgement that diagnosis and treatment may involve risks of injury. I acknowledge that no guarantees have been made to me as a result of examination of treatment. I hereby authorize The Physical Edge to retain any records for use, for research and for teaching purposes. I understand that The Physical Edge is a teaching clinic for physical therapy graduate students. I also understand that there will be instances when a student will perform my evaluation or my treatment under the direction and guidance of the attending physical therapist. If I would prefer to not be treated by a student I know that it is my right to inform my treating physical therapist.

If I refuse treatment that is suggested for me, I will not hold Clinic or any individual responsible for any consequences resulting from my decision.

I have had full opportunity to read and consider the contents of the Consent for Treatment. I understand that, by signing this Consent form, I am giving my consent to treatment and attest that I am aware and understand all of the above.

_____ _____

Patient Guardian/Responsible Party Signature Date

_____

Patient Guardian/Responsible Party Print Name

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Patient Acknowledgement of HIPAA OMNIBUS Privacy Act

I have read the material provided me regarding the HIPAA OMNIBUS Privacy Act, and understand my rights and choices.

I also have read and understand the material in regard to the clinics responsibilities under the HIPAA OMNIBUS Privacy Act.

I have Also been informed that I can obtain further information regarding the HIPPA OMNIBUS Privacy act at the following website:
www.hhs.gov/ocr/privacy/hipaa/understanding/customers/index.html

I therefore freely affix my signature below with full understanding of all of the above.

_____ _____
Patient Guardian/Responsible Party Signature Date

_____
Patient Guardian/Responsible Party Print Name

Patient acknowledgement of NTC 12 01

Physical Therapy Board of California

I have read, and understand the California Physical Therapy Board's Information informing me of the following:

The Scope of the physical Therapy Aide
The Licensure of Physical Therapists, and Physical Therapist Assistants
The email address of the Physical Therapy Board, where I can get information on:

- Verifying a license
- What to expect when I receive care
- My rights as a patient
- How to file a complaint

_____ _____
Patient Guardian/Responsible Party Signature Date

_____
Patient Guardian/Responsible Party Print Name

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MEDICAL HISTORY

Do you have/or have you had any of the following:

Problem			Date of Onset	Comments
High Blood Pressure	Yes	No		
Heart Disease	Yes	No		
Heart Attack	Yes	No		
Pacemaker	Yes	No		
Cardiac Surgery	Yes	No		
Diabetes	Yes	No		
Cancer Type _____	Yes	No		
Neurological Disorder Type _____	Yes	No		
Headaches/Migraines	Yes	No		
Asthma/Respiratory Problems	Yes	No		
Dizziness/vertigo	Yes	No		
Incontinence: urinary or bowel	Yes	No		
Nervous/Psychological Disorder Type _____	Yes	No		
Arthritis: Osteo Rheumatoid	Yes	No		
Osteoporosis	Yes	No		
Other: _____ _____				

Please enter the date of injury for what you are being seen for today: _____

Surgeries: _____ _____ _____
Date Date Date

Allergies: _____ _____ _____

Hearing problems: Yes No VISION PROBLEMS: YES NO Are you/could you be pregnant? Yes No

Metal Implants: Yes No Area(s)_____ Weight: _____LBS Height: _____FT

Patient Name: _____ **Date:** _____

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Patient Name (Print):_____ Date: _____

In this list please include ALL known prescriptions, over-the-counters, herbals, and vitamins/mineral/dietary (nutritional) supplements.

Medications Name	Dosage	Frequency	Route of Administration

If more space is necessary please ask front desk for an additional sheet.

253 N. Santa Anita Ave. Arcadia, CA 91006 ♦ (626) 294-0070 Fax (626) 294-0080