Mission Physical Therapy

Pre-Exam

Name: ____ Date: ___________

Where is your pain/problem? __________________________________

What caused it? ____

*W*hen did it start or when did it most recently flare up? _____ /_____ / 20______

Have you before or are you now being treated by another clinician for this or other

orthopedic problem(s)? If so, who? _____________________________

Have you ever had this pain/problem before? Yes No

List all past surgeries with dates and medical conditions you have:

List all medication you take (or you may provide a list):

I understand that my candidacy for a rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The physical therapist will determine whether or not I am a viable candidate for a rehabilitation program and that my activation into their system is not guaranteed.

Signature: _______________________________________ Date: _________

Important Company Policies

We strive to provide you the best personal care available. To make this possible we adhere to a set of very important policies. Please read then initial each item to indicate your agreement.

____ **15-minute Late Policy** You may lose your appointment if more than 15 minutes late. We do not allow appointment overlap as this compromises your care and the care of others.

____ **No-shows** If you fail to show for an appointment without 24-hour notice all future appointments will be removed and a *$25 fee* assessed. You may re-schedule appointments again on a "first come, first serve basis". If you wish to change or cancel an appointment we require a minimum *24-hour advance notice*. Anything less will result in a *$25 fee* charged to your account, which is to act as a deterrent from making last minute changes. Advance notice allows someone else time to reserve it in place of you. Please be courteous and responsible.

____ **Cell phones must be shut OFF or silent.**

____ **Children requiring supervision are NOT allowed to attend sessions with you.**

____ **Authorization to use your testimonial and/or photograph in our marketing:** Your testimonial will help others get a better understanding of our services/products as well as help us get the message of our services and programs out to the community. Whether it's a video or written testimonial, we ask you to be honest and genuine with your comments. You may request Mission Physical Therapy to stop using your testimonial, video, and/or picture at any time by written request. Any advertisements or promotions already existing on the company website and/or printed materials prior to your stop request will be allowed.

____ **Financial Hardship:** If you are experiencing financial difficulties and are unable to afford the cost of our services we have a Financial Hardship Form which may be filled-out. If you qualify for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your portion of the bill. Ask the front desk person for assistance.

____ **Copays are due at the time of service** **Important Notice from the Federal Government**
"It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments–even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP's - Take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A(a)(5) of the Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA]. Exceptional cases do apply. Office of Inspector General, Department of Health and Human Services. Phone: (202)619-1343, FAX: (202)260-8512, Email: paffairs@oig.hhs.gov, Mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building, 333 Independence Avenue, S.W., Washington, D.C. 20201

We look forward to building a relationship with you that will last a lifetime!

I have read and agree to all of the above company policies

____
Signature

Lastly, I would like to receive a newsletter by mail ___, by email ___, or I politely decline ___.