russ PHYSICAL THERAPY
solutions. action. improved lives

1002 SW Westpark Dr., Ste. 6, Bentonville, AR 72712 P-479-250-4014 F-479-250-4015

PATIENT AUTHORIZATION FOR TREATMENT/INFORMED CONSENT

APPOINTMENTS: Patients are seen by appointments only and therefore, it is advisable for you to schedule your appointments in one or two week intervals. If you do need to cancel, please give 24-hour notice. **Any missed appointments may result in a $60 cancellation/no show fee. This charge will not be covered by insurance, but will have to be paid by you personally prior to receiving additional treatment.** _____ (Please Initial)

CONSENT FOR CARE AND TREATMENT: Russ Physical Therapy will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I the undersigned do hereby agree and give my consent for **Russ Physical Therapy** to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition._____(Please Initial)

I authorize Russ Physical Therapy to contact me via phone call, text message, and e-mail for appointment reminders and promotions. (We value your privacy and will NOT give/sell this information to other business.) _____(Please Initial)

RELEASE OF INFORMATION / ASSIGNMENT OF BENEFITS: All information provided herein is true and correct. I give permission to Russ Physical Therapy to release/obtain information, verbal and written, contained in my medical record, and other related information, to/from my insurance company, case manager, attorney, related healthcare provider, assignees and/or beneficiaries and all other related person, as needed. I authorize irrevocable direct payment to Russ Physical Therapy for services rendered. _____(Please Initial)

NON-COVERED SERVICES: I understand that I am responsible for charges not covered or reimbursed by my insurance I understand that I am financially responsible for all charges whether or not paid by insurance._____(Please Initial)

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that **RUSS PHYSICAL THERAPY'S HIPAA** Privacy Notice can be found in the white binder in the waiting area. I understand the content of the Notice of Privacy Practices and will be provided with a copy upon my request. I acknowledge that **Russ Physical Therapy** may disclose my "protected health information" (PHI) in compliance with HIPAA Privacy Provisions which may include my medical records, to any third party payers, including, but not limited to health insurers, health care service plans, state and federal agencies, workers compensation carriers. This includes appropriate release and disclosure of my medical records in compliance with Privacy Provisions to my physicians and other health care providers when necessary for my treatment and general health. I give **Russ Physical Therapy** my permission to take my picture for identification purposes.

HIPAA PRIVACY NOTICE: I acknowledge that I have been given the opportunity to review **Russ Physical Therapy's** HIPAA Privacy Notice and its contents. _____(Please Initial)

I have read, understand and agree to all the policies as stated above.

X_____

Print Name | Patient or Guardian Signature | Date

X_____

Print Name | Russ Physical Therapy Signature/Witness | Date

CONSENT FOR TREATMENT OF A MINOR: I authorize **Russ Physical Therapy** to treat _____ while I am not present. (Minor's Name)

X_____

Patient or Guardian Signature | Date

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PATIENT HEALTH QUESTIONNAIRE

Name:_____ Date:_____/_____/_____

Date of Birth:_____

Please describe your current complaint or limitation: _____

_____

Please describe how and when your problem began: _____

_____ Specific Date if possible:_____/_____/_____

Did you have surgery for this condition?

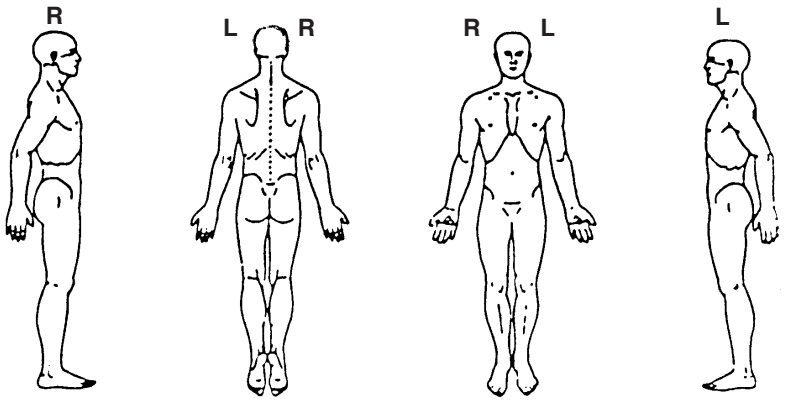
❑ No ❑ Yes Date:_____/_____/_____

Please describe the nature of your pain/problem:

❑ Sharp Pain
❑ Dull (Pain) Ache
❑ Throbbing
❑ Numbness
❑ Shooting
❑ Burning

❑ Constant (76-100%)
❑ Frequent (51-75%)
❑ Occasional (26-50%)
❑ Intermittent (25% or less)

MARK ON PICTURE WHERE ⇨⇨⇨
YOU HAVE PAIN OR OTHER SYMPTOMS.



Indicate the intensity of your ***pain at rest:*** (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Indicate the intensity of your ***pain with movement:*** (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Since this condition began your symptoms have: ❑ decreased ❑ not changed ❑ increased

Your symptoms are worse in: ❑ morning ❑ afternoon ❑ night ❑ increased during the day ❑ same all day

Have you had physical therapy treatment, for this condition, ***in the past***? ❑ No ❑ Yes

Have you had any falls with injury the past year? ❑ No ❑ Yes If you did fall, how many falls did you experience? _____

Occupation:_____ Has your work status changed because of this condition? ❑ No ❑ Yes

If you have ever had a listed condition in the past, please check in the PAST column. If you are presently troubled by a particular condition, check in the PRESENT column. The information you provide concerning past and present conditions and diseases assists your therapist in more thoroughly understanding your state of health.

PAST	PRESENT	
❑	❑	High Blood Pressure
❑	❑	Angina
❑	❑	Heart Attack
❑	❑	Stroke
❑	❑	Asthma
❑	❑	Dizziness
❑	❑	Tumor
❑	❑	Systemic Lupus
❑	❑	Muscular Weakness
❑	❑	Hepatitis
❑	❑	Epilepsy
❑	❑	Diabetes
❑	❑	Rheumatoid Arthritis
❑	❑	Arthritis
❑	❑	Pregnancy
❑	❑	Headaches
❑	❑	Recent weight gain or loss
❑	❑	Musculoskeletal Disorder (ie: osteoporosis, muscle pain, fractures)
❑	❑	Depression
❑	❑	Cancer Location:_____ Date:_____
❑	❑	Other_____
❑	❑	Numbness/Tingling

Hospitalization/Surgical Procedures:
(list if not described elsewhere)

_____

_____

_____

_____

Medications: _____

_____

_____

_____

_____

Referring Physician: _____

How did you hear about us? _____

_____
Patient's Signature *Date*

Important Company Policies for a Successful Relationship

We strive to provide you the best personalized care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully, initial all the boxes, and indicate your agreement by signing on the next page of this form.

Initial All Boxes

☐ **Late Policy "10-minutes"**

Being late by more than 10 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

☐ **24-Hour Advance Notice Fee**

If you wish to change or cancel an appointment, we require a minimum ***24-hour advance notice***. Anything less will result in a ***$60 fee*** charged to your account. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.). We don't charge you the actual cost for that appointment but rather a mere ***$60 fee***. We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.

☐ **Copays are due upon arrival**

If you happen to forget your wallet or checkbook we may still be able to see you upon completion of an "Extension Request" form. This is a "promise-to-pay" form and carries a minimal fee that allows you to keep your appointment.

☐ **No-shows are bad**

If you fail to show for an appointment without notice all future appointments will be removed and a ***$60 fee*** assessed to your account. You may re-schedule appointments again on a "first come, first serve basis".

☐ **Cell phones must be shut OFF or silent**

We realize emergencies may arise and therefore allow you to carry your cell phone during your session, how- ever, please be courteous and set to silent mode or turn off. Thank you.

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

Unless your facility offers child care services, you may not bring children who require supervision with you to your appointment. If your child does not require supervision and is capable of waiting for you quietly then you may bring them. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child.

☐ **Financial Hardship**

If you are experiencing financial difficulties and are unable to afford the cost of our services we have a "Finan- cial Hardship Form" which may be filled-out. If you quality for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your (patient responsibility) portions of the bill. Ask the front desk person for assistance.

☐ **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, Fed- eral Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penal- ties (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. Please see contact info for more information. Office of Inspector General, Department of Health and Human Services. Contact by by phone: 202 619-1343, by fax: 202 260-8512, by email: paffairs@oig.hhs.gov, by 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, Joel Schaer, Office of Counsel to the Inspector General, 202 619-0089."

☐ **Credit Card on File Policy**

I authorize and request Russ Physical Therapy to charge my credit card for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Russ Physical Therapy. This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 30-day notification and my account must be in good standing.

We look forward to building a successful relationship with you that lasts a lifetime! I have read, understand and agree to all the policies as stated above.

X _____

Print Name | Patient or Guardian Signature | Date

How did you hear about us? _____

LIST ANY MEDICATIONS, VITAMINS, HERBS, AND SUPPLEMENTS CURRENTLY TAKING

PATIENT NAME:_____
SIGNATURE:_____
DATE:_____

MEDICATION NAME	DOSAGE	FREQUENCY	ROUTE OF ADMINISTRATION