Next Level Physical Therapy PC
Existing Patient's In Next Level System For Previous Treatment

First Name ____________________________ M.I. ___________ Last Name ____________________________Date of Birth_______________

Street Address: ______________________________ City: _________ State:_____ Zip:________ Phone:(_____)_____-__________

Injury / Ailment ____**Date of Onset** ______________**Date of Surgery**____________

Physician: ____

Email: ____ **Email Appointment confirmation :** ○ **Yes** ○ **No**

HAS YOUR INSURANCE CHANGED SINCE YOUR LAST VISIT? YES___________ NO___________

(FILL OUT INFORMATION BELOW IF INSURANCE HAS CHANGED IN ANY WAY SINCE PREVIOUS VISIT)

Insured Person's Information

*****IF YOU PROVIDE US WITH INSURANCE CARD PLEASE SKIP THIS SECTION*****

Will we be billing insurance? ○ Yes (please provide Insurance Card)

Were you injured in a traffic accident? ○ Yes

Were you injured at work? ○ Yes

NAME OF INSURANCE/ or Compensation Carrier________________________________ Subscribers DOB ______________________

Name of subscriber Insured ____ Relation to patient: ○ Spouse ○ Parent Other ___________

Date of Injury: Mo____Day____Yr____

Claim Number/Policy number ____

Street Address of Insurance ____City/State/Zip ____________________________________

MEDICAL HISTORY

Please take a moment to complete the questions below. Depending on your answers, we may modify our treatment procedures for their effectiveness and your safety. Thank you!

Are there any new medical conditions we should be aware of that have changed since last visit? ______________________________

____

Current Medications ____

____

New Surgeries (What/Where/When) ____

____

Recent Illnesses (What/When) ____

____

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PLEASE FILL OUT COMPLETELY. THIS IS REQUIRED BY YOUR INSURANCE COMPANY FOR PAYMENT OF SERVICES

DATE OF ONSET:____

1. **Briefly Describe your symptoms**:

____

____

2. **How did your symptoms start?**

____

____

3. **Average pain intensity**

LAST 24 HOURS	no pain	0	1	2	3	4	5	6	7	8	9	10 worst pain
PAST WEEK	no pain	0	1	2	3	4	5	6	7	8	9	10 worst pain

4. **How often do you experience your symptoms**?

☐ Constantly (76%-100% of the time) ☐ Frequently (51%-75% of the time) ☐Occasionally (26%-50% of the time) ☐ Intermittently (0%-25% of the time)

5. **How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)**

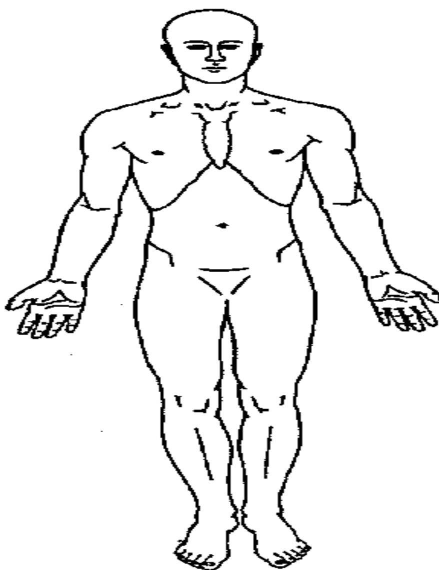
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

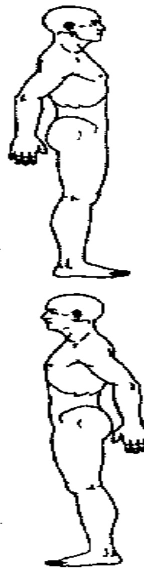
6. **In general, would you say your overall health right now is…**

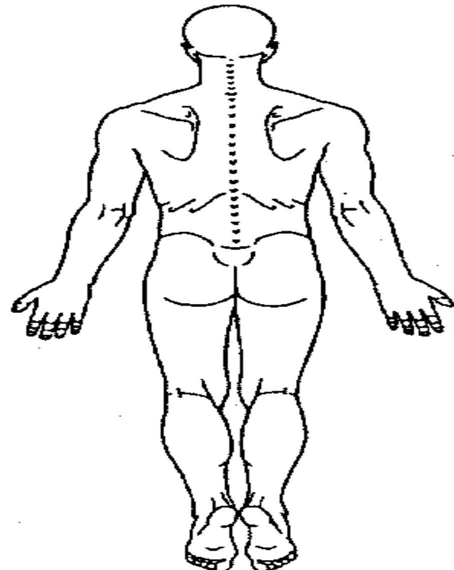
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Pain Diagram
Please mark the area of injury or discomfort on the chart below, using the appropriate symbols:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^ ^	X X X X	







Next Level Physical Therapy, P.C.
251 Violet Street, Unit 150
Golden, CO 80401
Phone (303) 279-6000 Fax (303) 279-7799

FINANCIAL POLICY STATEMENT

For and in consideration of services rendered by Next Level Physical Therapy, P.C. (Next Level) I agree to pay all fees in accordance with rates agreed to by me at the time of the service or based on the rates set forth in my Insurance Company's Explanation of Benefits (EOB). I further understand that I am responsible for those authorized fees not covered by my insurance company and for any co-payment that is established by my insurance company. Co-payments are due at the time of service.

If any payment is made directly to me by my insurance company for services billed by Next Level I recognize an obligation to promptly remit same to Next Level.

Cancellation / No Show Policy: Unless I cancel a set appointment at least 24 hours in advance, I will be charged for the missed appointment at the rate of **$35**. This fee is outside of reimbursable insurance coverage and is my sole responsibility. The first **two** will be waiver per our policy.

The above does not apply for those patients that are considered Worker's Compensation cases. However, be advised if W/C benefits are subsequently denied that I will be held responsible for the total amount of charges for services rendered to me. The prescription from the Doctor authorizing physical therapy must clearly indicate that workman compensation is involved.

I agree to pay all charges within 30 days of billing. Billing will occur at the earlier date of when the EOB is processed by Next Level 60 days after billing to the insurance company should the insurance company fail to reply. I agree to pay Next Level interest at the rate of one and one-half percent (1.5%) per month eighteen percent per annum (18%) for any amounts not paid with in 30 days of billing as defined herein.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, that I am responsible for interest as stipulated above as well as for all collection costs including but not limited to court costs, collection agency fees, and attorney fees.
× _(Initial)_

I. CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Next Level Physical Therapy, PC to furnish medical care and treatment to
× _(Initial)_ considered necessary and proper in diagnosing or treating his/her physical condition.

II. AUTHORIZATION TO RELEASE INFORMATION OR RECORDS

SECTION A:

I, hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to Next Level Physical Therapy, PC. A photocopy of this assignment is to be considered as valid as the original. I, hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment to be valid for life time of ninety-nine years (99) or upon death.

SECTION B:

I authorize the use or disclosure of my protected health information (PHI) as described below. I hereby give my permission to Next Level Physical Therapy, PC to use or disclose my PHI in the manner described herein.

SECTION C:

Personal Health Information to be disclosed:
We may call your home or office and leave a message in reference to any items that assist the office in coordination of care. Examples of these items would include such items as appointment reminders, insurance items needed, or other items related to your clinical care.
Purpose of the Disclosure: The disclosure is being made for the following reasons:

- For purposes of providing you timely information about appointments, insurance items or other items relation to your clinical care.
- Communication with doctors, referring providers in collaboration of your care.

× _(Initial)_

SIGNATURE:

My signature below acknowledges that I have read this Authorization, understand my rights as described herein, and authorize release of my PHI.

Signature Patient or Legal Guardian: × ______________________ **Date**: × ______________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with a copy of the Practice's Notice of Privacy Practices.

____
Print Name

___________________________________ __________
Patient (or Patient Representative*) Signature Date

For Practice Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) ____

*If Patient Representative is signing, legal documentation must be included designating authority to sign or receive information. This form must be maintained for 6 years.