Next Level Physical Therapy PC
Patient Information

First Name _____ M.I. _____ Last Name _____

Date of Birth _____ SS# (if minor, leave blank) _____ Student? ○ F/T ○ P/T ○ NO

Street Address _____

Billing Address (if different) _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Work Phone _____

Guardian Name (if minor) _____ Guardian Phone _____

Emergency Contact Name / **Relation to Patient** _____ / _____ Phone# _____

Email Address: _____ **Email Appointment Confirmation**: ○ **Yes** ○ **No**

○ Married ○ Single ○ Divorced ○ Widowed ○ Other

Physician Name _____

Name of Employer _____ Occupation _____

Employment status: ○ Full time ○ Part time ○ Retired

How did you Find Us?/Who Referred you to Next Level?: _____

Injury / Ailment _____ **Date of Onset** _____ **Date of Surgery** _____

Will we be billing insurance? ○ Yes (**please provide Insurance Card)**
Were you injured in a traffic accident? ○ Yes
Were you injured at work? ○ Yes

Billing & Communication Information

MINOR PATIENTS ONLY (if patient is under 18, you must supply Parent/Guardian information)

NAME OF PARENT/GUARDIAN: _____ **PARENT/GUARDIAN PHONE NUMBER:** _____

PARENT/GUARDIAN EMAIL BILLING: _____ **PATIENT RELATION:** ○ MOTHER ○ FATHER ○ Other _____

PLEASE PROVIDE ALTERNATIVE NAME EMAIL AND PHONE NUMBER FOR BILLING (if not same as above) _____

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.

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

Cancer	○ Yes	○ No	
Diabetes	○ Yes	○ No	
Epilepsy	○ Yes	○ No	
Heart Disease	○ Yes	○ No	
High Blood Pressure	○ Yes	○ No	
Metal Implants	○ Yes	○ No	If Yes, What _____
Respiratory Problems	○ Yes	○ No	
Are you Pregnant?	○ Yes	○ No	
Psychological Problems	○ Yes	○ No	
Blood Borne Pathogens	○ Yes	○ No	If Yes, What _____
Allergies	○ Yes	○ No	If Yes, What _____
Urinary/ bowel incontinence	○ Yes	○ No	

Are there any other medical conditions we should be aware of? _____

Current Medications _____

Surgeries (What/Where/When) _____

Recent Illnesses (What/When) _____

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

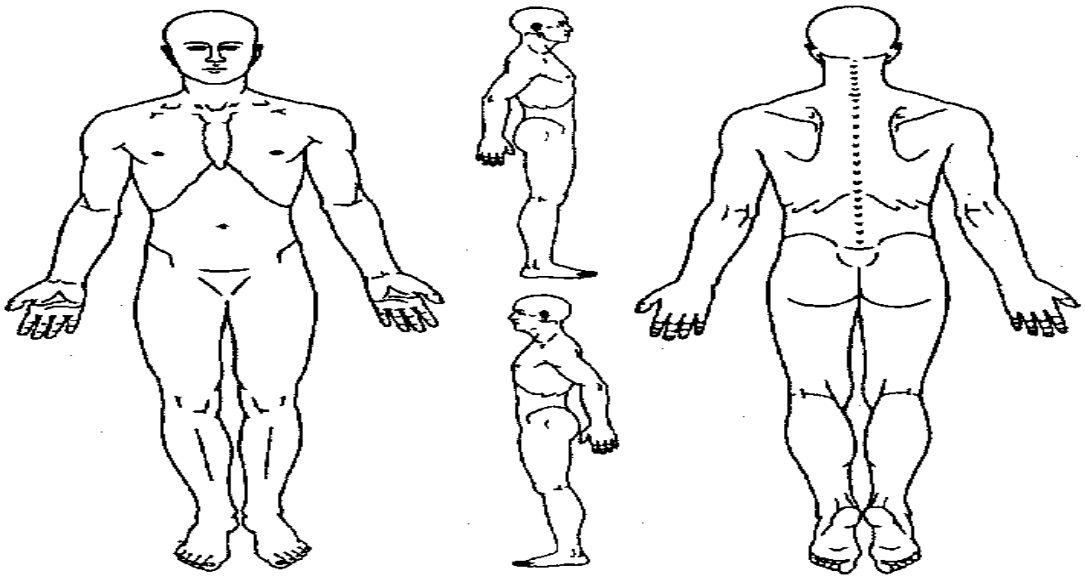
6. In general, would you say your overall health right now is…

☐ 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 o o o o o Burning ^ ^ ^ ^ ^ Aching **x x x x** Stabbing ▯▯▯▯▯▯▯▯



Next Level Physical Therapy, P.C.
4670 Table Mountain Drive
Golden, CO 80403
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** cancellations will be waived per our policy**. NO SHOW FEES WILL BE CHARGED NOT WAIVED.**

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.
x ***(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
x ***(Initial)*** considered necessary and proper in diagnosing or treating his/her physical condition.

II. AUTHORIZATION TO RELEASE INFORMATION OR RECORDS

SECTION A:

I, hereby allow the release of medical records to 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 lifetime 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.

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, other practitioner in collaboration of your care.

x ***(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: **x** _____ **Date**: **x** _____

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.

Next Level Policies, Procedures & Insurance Information

To provide you with the best quality of service here are some guidelines to help us perform our job better. Please read and sign and date at the bottom. Thanks!

Policies & Procedures

- Family can come back only on the first visit for initial physical therapy evaluation or initial training consult. After that we ask that family and friends, please stay up front for safety reasons.
- Here at Next Level, you can expect to see multiple professionals at any given appointment because of our team approach.

Insurance

- PT copayment is due at the beginning of each appointment
- To better your service we may suggest products that WILL NOT be covered under insurance.
- Do you have secondary insurance that we should be aware of (i.e. Medicare, Auto, Work Comp, School/University)? _____ **YES** _____ **NO**
  ***Please Be Aware we will not bill any secondary Insurance**
- Patient is responsible to inform Next Level of any change to insurance provider and/or billing address at any time.
- **A cancellation fee of 35 dollars** will be enforced if cancellation occurs within 24 hours of scheduled appointment. The first two cancellations will be waived.
- **NO SHOW FEES ARE NOT WAIVED**
- Please understand that your insurance company and benefits are unique and individual. Ultimately it is you, the member, who is responsible for knowing the details of your insurance policy**. If there is a denial of payment from insurance, you are responsible for full amount of services rendered per insurance explanation of benefits (EOB).**

Patient or Guardian signature _____ Date_____