DANIEL B. NEFF, DPT PHYSICAL THERAPY

Patient Name: ____ Birthdate: __________________

Authorized Person (If patient is a minor): _________________________Birthdate: __________________

Address: _________________________________ City: _______________________ St: ______ Zip: _____

Phone: ______________________ Email: ________________________ Physician: __________________

CONSENT FOR TREATMENT

During the course of treatment, you may experience an increase in your symptoms. In most circumstances this is a normal part of the recovery process. It is important for you to inform the clinical staff of any difficulties that you are experiencing. You may contact this facility at any time to discuss your status. If you believe that what you are experiencing is urgent or out of ordinary, please contact your physician. Please remember that your care is our top priority. We want to provide you with as much information and education that we can to help expedite your recovery. In the case of a minor patient (under the age of 18) I hereby authorize Daniel B. Neff, DPT Physical Therapy to administer physical therapy care deemed necessary for the course of treatment when I am unable to accompany my son/daughter for treatment. I understand the risks involved in physical therapy and agree to fully cooperate and to participate in all physical therapy procedures and to comply with the established plan of care.

Daniel B. Neff, DPT Physical Therapy will occasionally send out via email or mail, concerning upcoming workshops/newsletters and other clinical updates. Please indicate to us if you would prefer your address/email address not be included in the mailing by initialing this paragraph______.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE ACT

My signature below indicates that the Notice of Privacy Practices Act has been posted by Neff Physical Therapy for patients to review. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Neff Physical Therapy to release any of my protected healthcare information. This document will be signed annually unless otherwise specified by patient.

Signature of Patient or Authorized Delegate: ____

Date: ________________

FINANCIAL INFORMATION FOR NEFF PHYSICAL THERAPY

Patient: Please remember that we are not your insurance agent or an insurance specialist. We will help you to the best of our ability but will not be held accountable for any assistance. We have limited information concerning your insurance. We encourage you to call your insurance company to understand your outpatient physical therapy benefits. We will file a claim to your insurance company as a courtesy to you. Any patient having a secondary insurance, may have to submit their own claims if we do not have access to that insurance plan. We do not participate with any Medicaid programs, please advise our staff if you have a Medicaid product. Please be aware that most insurance's now need authorization. Patient's that need continued treatment after the initial authorization is used, may have to wait for a response from their insurance before we know if the requested additional visits are authorized. Should you, the patient, want to continue treatment without notification of additional visits being authorized, understand by signing this document that it may become your responsibility should the insurance not grant the additional authorized visits. Please ask Neff PT for specifics on your authorization and/or call your insurance company concerning any questions on your Physical Therapy authorization. Should your insurance company deem your treatment not medically necessary, you the patient may have some patient responsibility. Some insurance companies have visit limits. If you go over your visit limit for the year, we will charge you a fee for all your physical therapy after the visit limit has been exhausted. Please ask Neff PT for specifics.

PAYMENTS

All copays are due at the time of service.

All patients with a deductible will need to put down a form of payment. Patients will be notified of their balance. If a patient does not respond to the notification within 30 days, Neff Physical Therapy will process the card on file for payment of any balances.

Any patient wishing to have a payment plan will need to inform the billing office. A form of payment will have to be on file. All balances will need to be paid off within a 3 month period of time. Neff Physical Therapy will use the form of payment on file to collect any balances not paid within this 3-month period.

Please sign and date below that you have read and understand this document. Signatures are annual unless otherwise specified by patients

Signature: ____Date: __________________

AUTHORIZATION FOR THE RELEASE OF INFORMATION

1) Patient's Printed Name: ______________________________________ Date: __________

2) Daniel B. Neff, DPT Physical Therapy will only disclose the protected health information you want disclosed/released. I only authorize the release of information to the following person/entities: (please note all information will go to your referring doctor and/or insurance when warranted) Examples: Spouse, Parent, Friend, Other, Special requests

   1.______________________ 2. _____________________ 3. _____________________

3) I understand that I can refuse to give authorization without fear of retaliation or treatment limitations. I understand that if I give authorization, I may revoke it at any time by notifying Neff Physical Therapy in writing. I understand that the information used/disclose as a result of my authorization may be subject to re-disclosure by the recipient and my not be protected by Federal privacy regulations once in the recipient's possession. I understand if Neff Physical Therapy requests my authorization it is required to tell me the purpose and whom my PHI (protected health information) is being released to. I understand that I will receive a copy of this authorization, if I request it. Neff Physical Therapy will not be compensated for using or disclosing my PHI unless related to treatment or payment procedures unless specific permission is obtained by the patient after full disclosure of purpose & intent.
   Medicare Patients Only: I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Daniel B. Neff, DPT Physical Therapy for services furnished to me by that physical therapist. I authorize with my signature any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If other health insurance coverage is indicted on the HFCA-1500 my signature authorizes releasing of the information to the insurer or agency. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of Medicare as the full charge and the patient is responsible for the deductible, co-insurance or non-covered services. Co-insurance and deductible is determined by Medicare. I also attest that if I am receiving home healthcare, which may result in patient responsibility.

My signature below indicates that I have read and understand this document. Forms will be updated annually unless otherwise specified by the patient in writing.

Signature of Patient or Authorized Delegate_________________________________ **Date** ____

DANIEL B. NEFF, DPT PHYSICAL THERAPY MEDICAL HISTORY

Patient Name: ______________________________________ DOB: __________ Date: _________

Family Physician: ____

Please circle any that apply to your Medical History:

High Blood Pressure **Heart Disease** **Numbness** **Pacemaker** **Cancer**

Shortness of Breath **Female Issues** **Weakness** **Pregnant** **Night Pain** **Stroke**

Diabetes **Dizziness** **Headaches** **Irregular Heart Rate** **Fatigue** **Osteoporosis**

List any other Medical History: ____

Have you fallen in the past year? **Y** **N** Height: ______________ Weight: ________________

Medications: ____

Surgeries: ____

General Health: (circle one) **Poor** **Fair** **Good** **Excellent**

In the past 3 months have you experienced any significant changes in health? (Physical or Mental): ____

CURRENT COMPLAINT

Current Complaint: ____ Start Date: ____________

How did it start? ____ Previous Therapy: **Y** **N**

Does your pain radiate: **Y** **N** Where: ___________________ Pain Level (0 – 10) __________

Surgical Date if Applicable: _________________ Surgeon: ________________________________

Restrictions: **Y** **N** ___________________ Diagnostics Tests: __________________________

Signature ____Date: ____________

Diagnostic Testing Screening Tool

Patient Name: ___________________________ Date: ______________

Dear Patient:

If you currently feel or have felt any of the following symptoms within the past month or if you have been diagnosed with any of the following conditions, please check the appropriate boxes.

This is a screening tool that can help your Therapist and your Doctor determine what diagnostic tests* might be appropriate for you.

Please check all that apply:

	Low Back and Radiating Pain		Neck Pain and Radiating Pain
	Numbness, Tingling or Burning Sensation in the Legs or Feet		Numbness, Tingling or Burning Sensation in the Arms or Hands
	Weakness in the Legs or Arms		Loss of sensation in Hands / Feet
	You have Diabetes or Neuropathy		Daily alcohol 3 glasses or more
	Thyroid Dysfunction		Muscle Disease / Muscle Cramping
	Tendinitis / Bursitis / Arthritis		Shoulder Pain or Instability
	Elbow Pain or Instability		Wrist-Hand Pain or Instability
	Hip or Knee Pain or Instability		Ankle-Foot Pain or Instability
	Blurred Vision		Hearing Problems
	Dizziness of Vertigo		Headaches
	Unsteady gait		History of falls due to dizziness
	Hypertension		Hypotension
	Anything else you consider important:		

Patient Signature: ____________________________

*Electromyography/Nerve Conduction Studies, Autonomic System Testing, Somatosensory Evoked Potentials, Auditory & Visual Evoked Potentials, Musculoskeletal Ultrasound, Vestibular Testing