Welcome to

Patient Information: Date of Birth: _____________

____M___F___Other___
Last Name First Name Middle Initial Gender

Home Phone:________________ Work Phone:________________ Cell Phone:__________________

Physical Address:____

Mailing Address (if different):____

Employer:____ Occupation: ______________________________

Referring Physician: ___________________________Primary Care Physician: ___________________________

If you are being treated as a result of an accident, please complete the following:
Date of accident: _________ Please describe the nature of the accident & whether it was work-related:

Are you currently receiving **ANY** type of **Home Health Care** (nurse, homemaker, etc?) ________ If yes, PLEASE NOTIFY THE FRONT DESK **BEFORE** YOUR APPOINTMENT & provide us with the name of the agency.

Emergency Contact: ___________________________ Relationship: ____________ Phone #:_______________

Consent for Physical/Occupational Therapy Treatment and Acceptance of Financial Responsibility:
I am aware of the services provided by East Mountain Physical Therapy (EMPT) and hereby consent to said services. I authorize EMPT to release any medical records or information necessary to process this claim with my insurance company, if applicable. I authorize the release of any medical records from my physician, hospital, or others that would be pertinent to my treatment at EMPT. I authorize payment of benefits to EMPT for services rendered. I accept ultimate responsibility for payment of my bill including deductibles/co-insurance/co-payments due, as well as late fees, interest, and attorney/court/collection fees.

____ _______________
Patient Signature (parent/guardian if patient is under 18) Date

____ I consent to receiving appointment reminder messages on my telephone

____ I DO NOT consent to receiving appointment reminder messages on my telephone (PLEASE NOTIFY THE FRONT DESK IF CHECKING THIS OPTION!)

Patient Medical Information

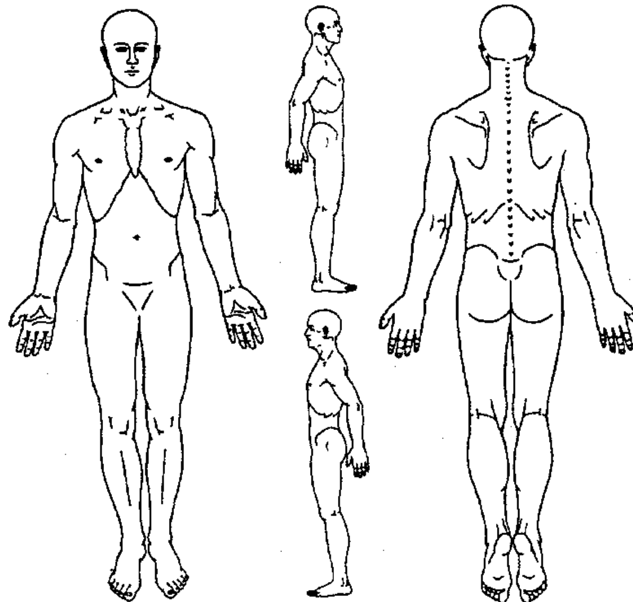
Do you currently have any of the following conditions (or have you in the past?)

Condition	***Now***	***Past***	***Comments/Location***
Arthritis			
Asthma			
Allergies			
Cancer			
Chest Pain			
Chronic Pain			
COPD			
Diabetes			
Emphysema			
Fibromyalgia			
Heart Disease			
High Blood Pressure			
Neuropathy			
Obesity			
Pacemaker			

Height ____________ Weight ____________ Current Medications: (please provide us with a list if lengthy)

Previous Surgeries (with approximate dates):

Please indicate the location of your pain below:



Patient Responsibilities / Code of Conduct

In order to provide a safe and healthy environment for staff, visitors, patients and their families, we expect patients and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

As a patient visiting our practice, you agree to the following:

Please make every attempt to **arrive on time** for your appointment. We don't "double-book." We are reserving that hour for you! Please give us **advance notice of any cancellations**. We normally have a waiting list & can attempt to fill your appointment if we have enough notice. You don't have to wait until we are open to cancel. **Messages are checked after hours and on weekends.**

If you are **sick**, please stay home! We will gladly re-schedule your appointment.

Please be courteous with the use of your **cell phone** and other electronic devices. When interacting with any of our staff, please put your devices away. Set the ringer to vibrate before storing away.

If you must bring **children** to your appointment, please make sure they have adequate supervision.

Please **dress** appropriately for your appointment. ***Modest*** gym attire is recommended.

We have a zero-tolerance policy for aggressive behavior toward our staff or other patients in the clinic. This includes making inappropriate comments, gestures or contact, or the use of profanity, comments that are derogatory/offensive to any race, religion, gender, or sexual orientation, or sexually suggestive comments/behavior. ***Anyone who is subjected to or witnesses aggressive or inappropriate behavior should report it immediately to any staff member. Violators are subject to removal from the facility and/or discharge from the practice.***

Patient Name: ____

Patient/Guardian Signature:___________________________________Date: ___________________

Cancellation/No-Show Policy

Your time is valuable! We will make every effort to begin your treatment promptly. We look forward to providing you with the best possible care during your hour-long appointments. Please arrive on time so that you can get the most from your therapy.

Our time is also valuable! You'll get an automated reminder message 24 hours before your appointment. We ask that you contact the clinic where you are scheduled ***as soon as you know*** you need to cancel or re-schedule your appointment. You ***do not need to wait*** until we're open to cancel your appointment. Messages are monitored regularly (including after hours and on weekends). We are reserving an hour of your therapist's time for you, and we have other patients needing appointments. With enough notice, we can fill your appointment with patients on the waiting list. We appreciate you allowing someone else to benefit from your cancellation.

We may contact you about your appointments if we need to make a change. We ask that you ***respond as soon as possible***.

If you ***cancel*** appointments regularly, we will ask you to move to the waiting list. You can also call for same-day openings due to other cancellations.

If you ***don't show*** for an appointment, we will contact you right away. If we are unable to get a response, your future appointments will be cancelled.

By following this policy, we avoid having to charge cancellation fees whenever possible.

Patient Name :_______________________________

Patient Signature (or Legal Guardian): ___________________ Date: _______

Insurance Benefit Verification Policy

While we make every effort to obtain accurate information about your physical/occupational therapy benefits from your insurance company ***prior to your first visit***, you are ultimately responsible for understanding your insurance coverage. We will provide you with the most accurate information possible, but sometimes we're given incorrect information.

If we discover that we have overcharged you for your portion of the therapy (once your claims process), we will promptly refund the money to you. If your insurance company pays **LESS** than we were originally told, you will be responsible for **additional** co-insurance/deductible amounts per your contract with your insurance company.

If your insurance terminates after we've verified coverage, **you will be responsible for payment**. Please notify us about ***any insurance changes as soon as you're aware***. Some carriers require prior authorization. If we are not aware of changes and miss these deadlines, you will be responsible for denied visits. Communicating with us regarding insurance changes will help avoid any unexpected charges.

Patient Name: ________________________________ Date:_____________

Patient (or Legal Guardian) Signature:____________________________________

Medicare Patients: Home Care Notification

MEDICARE will not pay for HOME HEALTH CARE and OUTPATIENT PHYSICAL/OCCUPATIONAL THERAPY at the same time. (Rare Exception: Patients on Hospice may receive therapy if not related to the Hospice diagnosis)

We must make sure that you are discharged from home care **BEFORE** seeing you in our office. If you start receiving home care while you are being seen in our office, **Medicare will ONLY pay for the home care.**

You will be **FINANCIALLY** responsible for the cost of therapy in our office if you are also receiving any Home Care Services covered by MEDICARE *(**even if they aren't therapy-related**).*

Please communicate with our front office about any home care services!

Patient Name: ____________________________________

Patient Signature: ______________________________ Date: _______

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by East Mountain Physical Therapy (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 12127B3 N. Hwy 14, Cedar Crest, NM 87008, Attention: Compliance Officer

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

   I request the following **RESTRICTIONS** be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions):

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

____ ____________________
Signature of Patient or Representative Date

____
Patient's Name

____ ____________________
Name of Personal Representative (if applicable) Relationship to Patient

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To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

_________ Accepted _________ Denied _________ Not Applicable

_________Other (explain) ____

____ ________________
Signature of Authorized Practice Representative Date