Patient Express Registration

COMPETITIVE EDGE physical therapy & fitness

Today's Date:

1. Patient Info

Please Fill-Out Entire Form Completely & Legibly.

❑ Male ❑ Female

Last Name _____ First Name _____ Age _____ Date of Birth _____/_____/_____

Street/Mailing Address _____ City _____ State _____ ZIP _____

Home Phone (_____)_____ Cellular (_____)_____ Email Address (May we contact you via email? ❑ **Yes** ❑ **No**) _____

Occupation _____ Employer Name _____ Phone # (_____)_____

Emergency Contact Person _____ Phone # (_____)_____ If Patient is a MINOR: Parent/Guardian Name and Signature Here _____

Primary Care Physician _____ Phone (_____)_____

❑ Single ❑ Married ❑ Divorced ❑ Widowed

Work Status: ❑ Currently Employed ❑ Retired ❑ Disabled (__Total or __Temporary) ❑ Student (__P/T__F/T)

2. My Condition Info

ALL INFO REQUIRED

My injury/ailment is related to . . .

❑ AUTO Date of accident: _____/_____/_____

❑ PERSONAL INJURY Date of accident: _____/_____/_____

❑ WORK INJURY: Date of injury: _____/_____/_____

Your company HR person name_____

Insurance adjustor name_____

Insurance adjustor PH#_____

I have already had . . .

❑ SURGERY: When and what type?

❑ PHYSICAL THERAPY: When and where?

❑ HOME HEALTH Care: Are you still receiving it? ___YES __NO

❑ OTHER care (please circle):

Chiropractor Doctor Acupuncture

Naturopathic Massage

3. Payment Info

(Check only one box)

I am paying TODAY by . . .

❑ **INSURANCE** and would like to . . .

__ Have you deal directly with them. I will assign my benefits to you by completing the **"Assignment of Benefits Form"** (Fees may apply in some cases). The following information is required prior to 1st visit.

My coinsurance/copay is $_____

My deductible is $_____

❑ **WORKERS COMP** . . .

You must have all info provided under "My Condition...".

❑ **CASH, CHECK, CREDIT**

❑ I have an **ATTORNEY** and would like to . . .

__ Wait until my case settles before paying. I will complete the "Attorney Lien" form. Fees may apply.

4. Referral Info

How did you hear about us?

❑ Friend or Family ❑ Brochure ❑ Other

❑ Web site ❑ Insurance Company / Directory

❑ Advertisement ❑ Phone Book

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 other side of this form (bottom).

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 ***$10 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 ***$10 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 ***$10 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 "Financial 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, Federal 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 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."

We look forward to building a successful relationship with you that lasts a lifetime!

COMPETITIVE EDGE
physical therapy & fitness

Assignment of Benefits

Patient Name: _____

Insurance Company and ID: _____

Insured Name:_____

Insured Date of Birth_____

Your relationship to the Insured: ❑ Self ❑ Parent ❑ Spouse ❑ Other:_____

I hereby instruct and direct the above insurance company to pay by check or electronic funds transfer to:

Competitive Edge Physical Therapy and Fitness, LLC
P.O. Box 955
Eagle, CO 81631
970-328-5549

If my/this current policy prohibits direct payment to Competitive Edge, I hereby also instruct and direct you to make out the check to me and **mail it to the above address** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

- ❑ A photocopy of this Assignment shall be considered as effective and valid as the original.
- ❑ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- ❑ I authorize the use of this signature on all insurance submissions.
- ❑ I authorize Competitive Edge Physical Therapy to deposit checks made in my name.
- ❑ I authorize Competitive Edge Physical Therapy to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- ❑ I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this _____ day of _____, 20_____.

_____ _____

Signature of Policyholder

Signature of Claimant, if other than Policyholder

Informed Consent and Policies Agreement

Medical Necessity
All treatments must be justified and medically necessary in order for us to treat and bill your insurance. Some of the factors that determine whether or not treatment is medically necessary are:

1) Does your condition interfere with the quality of your life?
2) Does your condition interfere with your ability to perform work or daily activities?
3) Are you motivated and able to participate in your treatment program and follow home and self-care instruction?
4) Is there potential for your condition to improve and/or resolve? If not, is there potential for your function or ability to perform daily activities to improve through modified movement, assistive devices, etc.?
5) Are there specific goals set that are measureable and track-able?

If the above criteria are not met, you are welcome to participate in our elective services such as 830laser, massage, myofascial treatments, fitness/exercise training, Pulsetron, Posture Program, etc. payable out-of-pocket by cash, check or credit card.

Cancel/No-show/Late
Please refer to the Express Registration Form.

Authorization for Release of Records
Assignment of Benefits (for insurance patients*)*
Please refer to the Assignment of Benefits form.

Results
The purpose of physical/occupational therapy is to maximize your body's own healing potential through natural means and promote your ability to perform daily, work, and leisure and sports activities through increased strength, flexibility, agility, and movement strategies. It is not possible to predict the results or outcomes of treatment. Sometimes benefits are realized immediately and sometimes it's more gradual over time.

Insurance Patients
It is your responsibility to know your benefit and insurance coverage for physical therapy services, including any maximums or exclusions. You are responsible for all charges whether paid by insurance or not. Any balances that exceed 30 days may incur fees and collection costs.

Medicare Patients
If you do NOT have supplemental insurance, you will be responsible for the twenty percent (20%) co-insurance portion not paid by Medicare as well as any deductible amounts not yet met. It is your responsibility to keep track of therapy cost totals for the purpose of not exceeding the Therapy Cap (unless your diagnosis is exempt from the Cap).

Minors and Parents
If patient is a minor (under 18 years of age), the parent or legal guardian is responsible for all charges and decisions made by the minor. We do not assume any liability for the minor while on premises or not, and it is the responsibility of the parent or guardian to supervise the minor before, during and after treatments.

Informed Consent
By signing below, the patient gives the therapist permission to the evaluation and treatment. It is your right to accept or refuse any treatment offered. There are no guarantees made as to the results that may be obtained from our treatment(s). If you have any questions about your care, be sure to ask the therapist.

It is up to patient/caretaker to inform the therapist/staff about any health problems or allergies patient may have. Patient/caretaker must also tell the therapist/staff about drugs or medications being taken as well as any medical conditions and/or surgeries.
Please discuss any questions or problems with the therapist before signing this statement of understanding and consent for care.

Patient Declaration
The therapist has explained to me the type of treatments ideal for my condition and the benefits of therapy, along with the risk of NOT receiving treatment. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent and policies form.

I have read and understand the foregoing explanation of rehabilitation/therapy care given to me. I hereby give my consent for the therapist to render treatments to me.

_____ _____
Patient Signature/Date **Patient's Representative Signature/Date**

_____ _____
Witness Signature/Date **Relationship to Patient**

COMPETITIVE EDGE PHYSICAL THERAPY AND FITNESS
P.O. Box 955, Eagle, CO 81631
970-328-5549

COMPETITIVE EDGE
physical therapy & fitness

Statement of Privacy Notice

Effective July 1, 20124

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

We may disclose your health information in the course of any administrative or judicial proceeding.

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

We may disclose your health information to coroners or medical examiners.

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

We may disclose your health information for military, national security, prisoner and government benefits purposes.
We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.

In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice.

We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at **(970) 328-5549**. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at **(970) 328-5549** . If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:
DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide the company above with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____ _____
Patient's Name (print) Signature Date

_____
Authorized Facility Signature Date

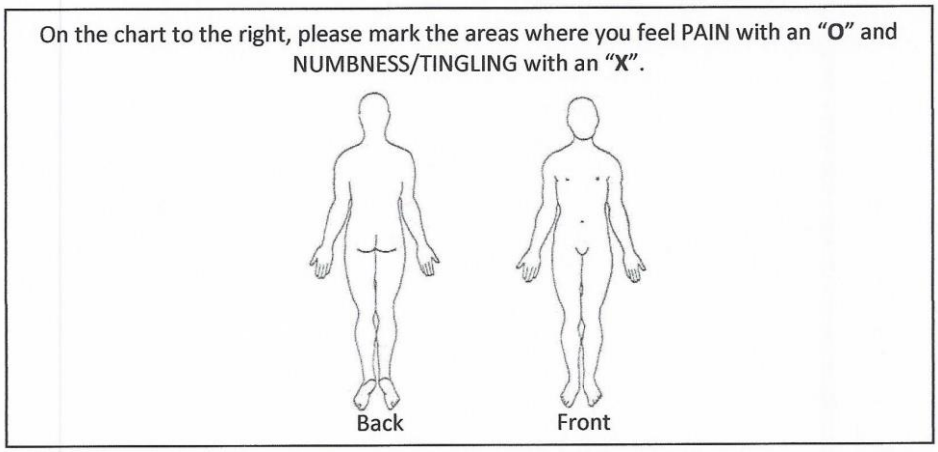
Patient Name:_____

COMPETITIVE EDGE physical therapy & fitness

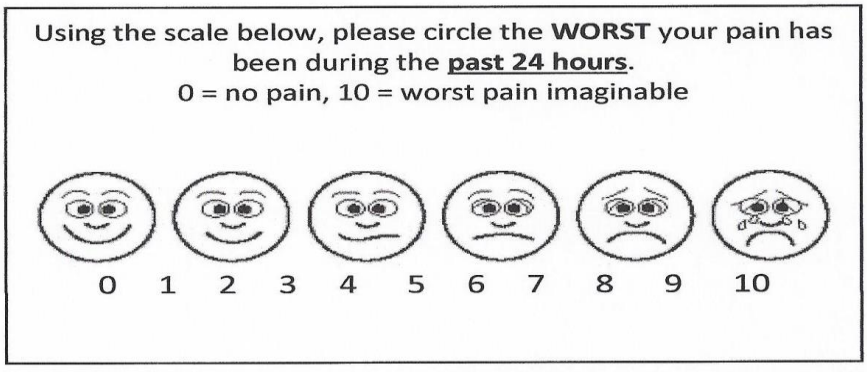
Physical Therapy Pre-Exam Questionnaire

In order to evaluate your condition fully, please be as accurate as possible. Thank you.

1. Are you working now? ☐ Yes ☐ No
2. Have you had physical therapy before? ☐ Yes ☐ No
3. Where is your pain/problem?



4. What caused your pain/or problem? _____
5. Approximately when did it start? ___/___/20____
6. Is it getting worse, better, or staying the same?_____
7. Have you ever had this pain/problem before? ☐ Yes ☐ No
8. Is your pain constant (never goes away)? ☐ Yes ☐ No
9. On the scale below <u>circle</u> your worst pain level in the past couple of days:



10. Are any of your usual everyday activities affected? ☐ Yes ☐ No

- If yes, describe how.

11. Please list all medications you are currently taking, including pills, injections, skin patches, vitamins, herbs, supplements, etc.

Medication Name	Why are you taking this?	Dosage	Frequency	Route of Administration (circle how you take this medication)
				Mouth, injection, patch
				Mouth, injection, patch
				Mouth, injection, patch
				Mouth, injection, patch
				Mouth, injection, patch
				Mouth, injection, patch
				Mouth, injection, patch

Do you smoke? □ Yes □ No Are you latex sensitive? □ Yes □ No

Do you have a pacemaker? □ Yes □ No List any known allergies_____

FOR WOMEN: Are you pregnant or think you might be pregnant? □ Yes □ No

Have you RECENTLY had any of the following (check all that apply)

- Fatigue
- Fever/chills/sweats
- Nausea/vomiting
- Weight loss/gain
- Falls
- Difficulty maintaining balance
- Numbness or tingling
- Muscle weakness
- Dizziness/lightheadedness
- Heartburn/indigestion
- Diarrhea
- Constipation
- Changes in bowel/bladder function
- Difficulty swallowing
- Shortness of breath
- Fainting
- Cough
- Headaches
- Currently feeling down or hopeless

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- Cancer
- Heart problems
- Chest pain/angina
- High blood pressure
- Circulation problems
- Blood clots
- Stroke
- Anemia
- Chemical dependency
- Depression
- Lung problems
- Tuberculosis
- Asthma
- Rheumatoid arthritis
- Other arthritic condition
- Bladder/UTI
- Sexually transmitted disease/HIV
- Incontinence
- Thyroid problems
- Diabetes
- Osteoporosis
- Fractures
- Multiple sclerosis
- Epilepsy
- Kidney problems
- Ulcers
- Liver problems
- Hepatitis
- Other:_____

Please list prior surgeries and dates:_____

Patient Name: _____ Date:_____

Physical Therapist: _____

COMPETITIVE EDGE
physical therapy & fitness

Address is 247 Ring Neck, Eagle

From I-70, exit 147 at Eagle. Go south on Eby Creek Road to Hwy 6 roundabout.
Turn right onto Hwy 6, then first left onto Capitol Street.
Follow Capitol Street approximately 1 mile to three-way stop.
Turn left onto Brush Creek Road.
Take **second** left onto Brush Creek Terrace (Brush Creek Terrace Road is a loop)
Take first right onto Snow Goose and continue to the end.
Turn right on Ring Neck.
247 Ring Neck is the third house on the right (light green stucco).

--Please park in the driveway--