Precision Physical Therapy Policies and Agreement

At Precision Physical Therapy of Fayette LLC, it is our goal to provide you with the most compassionate and individualized physical therapy care. With one-on-one appointments, our evidence-based evaluation and treatment approaches will allow for the highest quality outcomes and care, while restoring your prior level of function. The following policies regarding referrals, insurance coverage, scheduling, and appointments are to ensure that these goals are achieved promoting an exceptional physical therapy experience.

REFERRALS: As of July 2015, patients no longer need a referral to begin receiving physical therapy services in the state of Georgia. In fact, a referral is not necessary until after the 8th visit or 21st day of service following evaluation. If treatment is required beyond this time period, a referral must be obtained from another healthcare practitioner to continue treatment. A referral is required in order to receive dry needling services.

INSURANCE COVERAGE: Precision Physical Therapy of Fayette, LLC directly bills patients at time of service. Though we do not bill insurance, we encourage patients to utilize their "out of network" benefits when receiving our services. This allows the patient to submit documentation to their insurance provider for reimbursement, which Precision Physical Therapy of Fayette, LLC can assist with by providing necessary documentation. However, please be aware that there is no guarantee of reimbursement from insurance providers, and we are not held liable for remuneration. *At this time government funded insurance plans (Medicare, Medicaid, Tricare) will NOT pay for services rendered in an out-of-network setting unless they are preventative and wellness services.*

SCHEDULING & APPOINTMENTS: The treating physical therapist and the patient will formulate a plan of care on the day of evaluation which will determine frequency of scheduled appointments. These appointments will typically last 1 hour and involve a combination of manual therapy techniques and therapeutic exercises. For patient convenience, we offer services in a private treatment setting at select local gyms, or we can come to the patient's office or home.
**Please note: A no show or cancellation less than 24 hours in advance will incur a $50.00 charge.*

PATIENT CONSENT, ACCEPTANCE, AND AGREEMENT: I agree with the above written policies of Precision Physical Therapy of Fayette, LLC. I acknowledge and understand that I am personally responsible for payment at time of service. I give my consent for treating physical therapist to evaluate and treat at his/her discretion.

Patient Signature: ____ Date: ________________

MEDICAL INFORMATION RELEASE AND CONSENT FOR COMMUNICATION

I authorize the release of pertinent medical records/information as needed in assistance with any medical claims process, as well as, situations which necessitate communication between Precision Physical Therapy of Fayette, LLC and other healthcare providers for the purposes of my care. This encompasses all forms of communication including but not limited to written documentation, telephone conversations, facsimile transmissions and email correspondence.

Patient Signature: ____ Date: ________________

Patient Contact Information

Name: ______________________ Today's Date:__________ DOB: __________

Address: ____

City: ______________________ State: __________ Zip Code: __________

Occupation: ______________________ Recreation: ______________________

Home Phone: ______________________ Cell Phone: ______________________

Accept text: Yes / No Accept email: Yes / No Email: ______________________

Emergency Contact Information

Name: ______________________ Relationship: ______________________

Home Phone: ______________________ Cell Phone: ______________________

Responsible Party Information (If applicable)

Name: ______________________ Relationship: ______________________

Home Phone: ______________________ Cell Phone: ______________________

I/We authorize Precision Physical Therapy, LLC to release all medical information and/or records to my requesting insurance company and/or physician.

____

Signature of Patient/Guardian Date

Patient Health Questionnaire

Name: ______________________ DOB: __________ Gender: __________

Primary Care Physician:______________________ Referred by: ______________________

History of current condition for which you are being treated?

____

Please list any tests/images completed for your current condition and dates (ie. MRI, CT, Ultrasound, X-Ray):

____

Have you had other treatment for your current condition? (ie: PT, Chiro, Massage)? If yes, please list providers.

____

What has had a positive effect/improved your complaint?

____

What has had a negative effect/worsened your complaint?

____

Please list *all* medical conditions, health concerns and pertinent medical information (including previous injuries).

____

History of any of the following? (Circle all that apply)

Head/spinal injuries	Recurrent headaches	Depression/Anxiety	High Blood Pressure
Meningitis	Stomach ulcers	Concussion	Blood Clotting Disorders
Heartburn/Indigestion	Shortness of breath	Stroke	Cancer
Anemia	Asthma	Loss of consciousness	Smoking
Bladder infections	Heart problems	Diabetes	Other pertinent conditions

Do you or have you had any of these symptoms in the *past year*? (Circle all that apply)

Change in bowel movement	Difficulty concentrating	Persistent joint pain	Chest Pain
Irritable Bowel	Persistent nose bleeds	Blood in bowel/urine	Difficulty sleeping
Vertigo/dizziness	Muscle spasms	Fatigue	Eating disorder
Trauma	Motor Vehicle Accident	Lightheaded/fainting spells	Blood Clot
Unexplained weight change	Pain at night	Unexplained Bruising	

Past Surgical History: Please list all past surgeries (please note year).

____

Please list *all* medication/supplements you are *currently* taking.

____

Please list all allergies.

____

I/We authorize Precision Physical Therapy of Fayette, LLC to release all medical information and/or records to my requesting insurance company and/or physician.

____

Signature of Patient/Guardian **Date**

Precision Physical Therapy
Advance Beneficiary Notice of Noncoverage (ABN)

Patient Name: ____ DOB: _____________________

According to insurance regulations, Precision Physical Therapy is required to have patients sign an Advance Beneficiary Notice of Noncoverage (ABN) if treatment is not covered by their insurance plan or if they should choose to not submit or disclose to their insurance company. Insurance regulations are very specific that this decision MUST be made by patients without pressure from the medical provider.

Should you choose to receive treatment by Precision Physical Therapy, or if you choose to exercise your right to not send your information to your insurance company, please check the appropriate reason, as well as select the billing option described below.

Please check only one box; we CANNOT check the box for you.

I Am Electing To Receive Treatment For The Following Reason:

❏ Maximum Benefits Have Been Or Will Soon Be Reached	❏ I Do Not Have Insurance Coverage
❏ Treatment Is Categorized As "Not Medically Necessary" By My Insurance Carrier Or Physician	❏ I Knowingly Am Selecting Direct Payment For Services Covered By My Insurance Carrier
❏ I Do Not Want My Medical Information Released To My Insurance Company	

I Am Electing The Following Billing Option:

❏ I want the services offered by Precision Physical Therapy. I am aware and understand that I am responsible for the bill. I agree to pay Precision Physical Therapy at the time all supplies are received and services are rendered.

By signing below I understand and have received this notice. A copy of this notice will be provided to you.

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Signature of Patient/Guardian **Date**