Welcome!

We are pleased that you have selected A.C.I.C. Physical Therapy for your rehabilitative care and physical therapy needs. Our goal is to have you pain free and functional again in as short of time as possible, but physical therapy is a process and based upon your diagnosis and current status, this process may take a few days or a few months. Please let us know how we can best serve you, since you are the reason why A.C.I.C. Physical Therapy was founded. We hope you enjoy your time with us as we dedicate ourselves to helping you reach your full recovery potential.

Please fill out the attached forms legibly accurately and completely. This information will be held in strict confidence in accordance with HIPAA as amended and is essential to ensure your understanding of our billing procedures, our determination of your physical therapy diagnosis and developing you complete, individualized, functional plan of care.

Thank you!

Your A.C.I.C. Physical Therapy Team

A.C.I.C. PHYSICAL THERAPY

Patient Information

Please legibly print all information in the spaces provided. Be sure to complete all applicable information.

Last Name _____ First Name _____ M.I. _____

Preferred Name _____ ☐ Male ☐ Female DOB _____ Age _____

Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Minor ☐ Other Spouse Name _____

Address _____ City _____ State _____ Zip _____

Home ( )_____ Cell ( )_____ Work ( )_____

Email Address _____ Occupation _____

Would you like to receive appointment reminders by email? ☐ Yes ☐ No

If patient is a minor, parent or legal guardian Full Name _____ DOB _____

Date of Onset/Injury _____ Cause of Injury _____

Referring Physician _____ Phone ( )_____

Primary Care Physician _____ Phone ( )_____

Emergency Contact Name _____ Relation _____ Phone ( )_____

How did you hear about/referred to A.C.I.C.? _____

Insurance Information

Have you received any therapy/treatment this year, such as chiropractic, physical, occupational, or speech therapy? ☐ Yes ☐ No
Have you made a claim under Workers' Compensation or an auto accident for this injury? ☐ Yes ☐ No

Primary Insurance

Insurance Company _____

Name of Insured _____ DOB _____ Relationship to Patient _____

Insured ID # _____ Group # _____

Secondary Insurance

Insurance Company _____

Name of Insured _____ DOB _____ Relationship to Patient _____

Insured ID # _____ Group # _____

If your injury is a Workers' Compensation case, due to an auto accident, or through a Lien, please complete the following:

Is your injury job related? ☐ Yes ☐ No Date of Injury _____ Claim # _____

Insurance Company _____ Phone ( )_____

Name of Adjuster _____ Phone ( )_____

Is your injury due to a motor vehicle accident? ☐ Yes ☐ No Date of Injury _____ Claim # _____

Is you injury due to a Premises Liability ☐ Yes ☐ No Date of Injury _____ Claim # _____

Attorney (if applicable) _____ Phone ( )_____

CONSENT TO TREATMENT & THERAPEUTIC PROCEDURES

I, _____, hereby consent to the therapeutic procedures outlined below to be performed by A.C.I.C. Physical Therapy and their associates.

I agree to be evaluated and treated for functional loss due to related nerve, muscle, and skeletal dysfunctions and/or pain. My results of the evaluation will be sent to my physician.

Updates in the form of a progress note will be done monthly, unless otherwise requested by the patient and/or physician, and sent to my physician.

I understand that treatments may include, but are not limited to:

- Joint and soft tissue mobilization
- Clinic and home exercise program including stretching, strengthening, and balance/coordination exercises that I will be trained in
- Functional retraining including posture and body mechanics
- Modalities such as heat, ice, electrical stimulation, and ultrasound may be used to decrease pain/swelling
- Special procedures such as taping and neuromuscular electrical stimulation
- Treatments will be delivered by a team of Physical Therapists, Physical Therapist Assistants, PT Interns, and PT exercise specialists/aides

I understand that I will be explained the purpose of the therapeutic procedures prior to receiving treatment and that I may refuse any therapeutic procedure or treatment at any time.

I understand that I may consult with other therapists and/or physicians at any time regarding my condition.

I understand that no guarantees of a successful outcome have been given to me.

I understand that I can ask questions at any time regarding any aspect of my physical therapy care.

You should inform your physical therapist regarding any significant change in your symptoms or activity e.g. before returning to sports, gym, etc.

Parents/guardians must attend all treatments unless otherwise agree to, in writing. Minor patients will be supervised while in our office, but not in public areas of the building complex.

I certify that I have read and understand the above consent statements.

_____	_____	_____
Patient Name (please print)	Patient Signature (or Legal Guardian)	Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____

I hereby acknowledge that I have received a copy of A.C.I.C. Physical Therapy's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____ _____

Patient Signature Date

_____ _____

Representative Signature (if applicable) Relationship to Patient

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FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices on the following date: _____. Acknowledgement could not be obtained for the following reason(s):

_____ Patient / Patient Representative refused to sign

_____ Emergency situation prevented us from obtaining acknowledgement at this time, will attempt at a later date

_____ Communication barriers prohibit obtaining acknowledgement (explain):

_____

_____

_____ Other (specify):

_____

_____

A.C.I.C. Representative: _____

MEDICAL INFORMATION RELEASE FORM

(HIPAA RELEASE FORM)

Name: _____ Date of Birth: _____

Release of Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:

[ ] Spouse

[ ] Child(ren)

[ ] Other

[ ] Information is not to be released to anyone

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call: [ ] my home [ ] my work [ ] my cell

Number: _____ If unable to reach me:

[ ] you may leave a detailed message/email

[ ] please leave a message asking me to return your call

[ ] other

The best time to reach me is _____(*day*), between _____(*time*)

You may also email me at: _____

Signed: _____ Date: _____

Witness: _____ Date: _____

FINANCIAL LIABILITY AGREEMENT

_____ I understand that all co-payments, co-insurances, deductibles, and cash payments are due at the time of services, unless other written arrangements have been made with our Practice Manager.

Forms of payment accepted: Cash, Check, Visa, MasterCard, Discover, American Express
Returned checks: A $25.00 service fee for the processing of returned checks will be applied to patient responsibility.

_____ I understand that if my insurance does not issue payment within 90 days of that date of service, I will be financially responsible for the entire balance. I may pursue my insurance carrier at the time to render payment and once settled if due, I will receive a refund for any overpayment.

_____ I understand that it is my responsibility to inform this office of any changes in my insurance coverage during my course of treatment. I am aware that there is a timely filing policy with my insurance and the office may not be able to re-bill if current insurance information is not furnished in a timely manner.

_____ I understand that this office will verify benefits at the time of service but I am responsible for knowing my benefits and will be responsible for contacting my insurance carrier for details. I understand that benefits quoted to me are only an estimate. **I understand that it is my full responsibility to know and understand my health plan.** I understand that A.C.I.C. is not responsible for any inaccurate information they receive from my insurance company.

_____ I understand that my insurance company may also require a current physical therapy prescription, a "Letter of Medical Necessity" written by my physician and/or preauthorization directly from my physician for therapy services. **This is your responsibility to obtain and that noncompliance with this may result in services not being reimbursed by your insurance company.**

_____ I understand that I will be financially responsible for all services or supplies that are NOT covered by my insurance. This includes Durable Medical Equipment such as taping. Unresolved financial disputes for non-payment of fees for services rendered will result in discontinuation of services and assignment of collection responsibility for this account to a professional Collection Agency.

_____ I understand that A.C.I.C. reserves the right to charge interest at the legal prevailing rate (up to a maximum 10% per annum) for late payments or multiple payment plans as necessary to manage the collection of my account.

_____ I understand that if it should become necessary to forward my account to a collection agency, I will be responsible for the fee charged by the collection agency for the costs of collection. I agree to authorize A.C.I.C. PHYSICAL THERAPY to release my medical information to my insurance company, physician(s), attorney(s), and to all other pertinent parties that may be involved in my claim or care.

I hereby authorize payment be made directly to A.C.I.C. PHYSICAL THERAPY for the benefits otherwise payable to me for services rendered.

By signing this form, I the patient (or legal guarding of the patient), have read, understand, and agree with the terms of this financial liability agreement.

_____ _____ _____

Patient Name (please print) Patient Signature (or Legal Guardian) Date

PATIENT COMMITMENT & MISSED APPOINTMENT POLICY

We strive to provide out patients with the utmost professionalism and excellence of service. Our commitment to your well-being and gain of your physical abilities is something everyone in our clinic takes quite seriously.

Because we care so much about you, we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

Your adherence to the recommended number or treatments is a vital component of your progress with our services; therefore, we have certain rules that need to be followed in order to ensure optimum results.

We expect you to keep all your appointments. Write down the time of your visits and let us know if you would like appointment reminders emailed to you.

If you need to re-schedule an appointment, we require a 24-hour notice. In such a case, please call our office to arrange for a make-up appointment with our Front Office Receptionist. The make-up appointment needs to be in the same week, preferably the very next day.

In an instance of cancellation without a 24-hour notice or no-show to a scheduled appointment, we reserve the right to charge you a $35 fee. The only exception to the cancellation fee is in the case of an emergency.

If there is repeated non-compliance (cancellations and/or no-shows) with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We greatly appreciate you as our patient and strive to accomplish wonderful results and success for you.

I certify that I have read, understand, and agree to adhere to the above policy.

_____

Patient Name (please print)

_____ _____

Patient Signature (or Legal Guardian) Date

MEDICAL HISTORY AND PHYSICAL CONDITION

NAME: _____ DATE: _____

Chief Complaint: _____ Date of Injury / Onset: _____

1. Do you now have or have you in the past, had any of the following conditions:

Allergies	yes☐ no☐	Hernia	yes☐ no☐
Balance Problems	yes☐ no☐	High Blood Pressure	yes☐ no☐
Cancer	yes☐ no☐	HIV / AIDS	yes☐ no☐
Circulatory Problems	yes☐ no☐	Kidney Problems	yes☐ no☐
Diabetes	yes☐ no☐	Nervous Disorder	yes☐ no☐
Dizzy Spells	yes☐ no☐	Numbness / Tingling	yes☐ no☐
Headaches	yes☐ no☐	Pregnancy	yes☐ no☐
Hearing/Vision Problems	yes☐ no☐	Respiratory Problems	yes☐ no☐
Heart Attack	yes☐ no☐	Seizures	yes☐ no☐
Heart Disease	yes☐ no☐	Sensitivity to heat/cold	yes☐ no☐

If yes to any of the above, please explain and give approximate dates of occurrences:

_____

_____

2. Have you had treatment for this / these problems before? Yes ☐ No ☐

   If yes, where and when were you treated? _____

3. Have you had surgery related to this / these problems? Yes ☐ No ☐

   If yes, what type of surgery did you have and when was the surgery? _____

4. Do you currently have any metal implants? Yes ☐ No ☐

5. Do you currently have a pacemaker? Yes ☐ No ☐

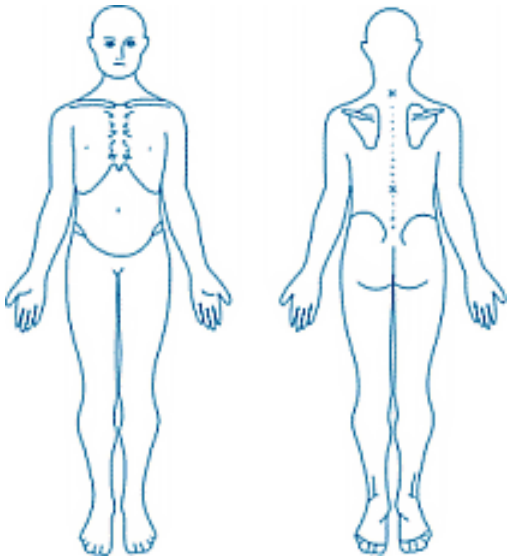
6. Do you have any communicable diseases? Yes ☐ No ☐

7. List all medications you are currently taking, including vitamins/supplements:

_____ _____ _____ _____

_____ _____ _____ _____

Please indicate on the body chart below, the location of your injury or condition. Also indicate the quality of your injury, condition, or pain (i.e., ache, sharp, dull, weakness, shooting, etc.)



On a scale from 0 to 10, please indicate the range of your discomfort/pain (best to worst):

0 1 2 3 4 5 6 7 8 9 10

NO PAIN UNBEARABLE

Symptoms are aggravated by: _____

Symptoms are eased by: _____

Symptoms are better in the: am_____ pm_____

Please check those activities that you are unable to perform since your injury / surgery and would like to resume.

Walking	[ ]	Activities of Daily Living:	
Running	[ ]	Dressing	[ ]
Going up/down stairs	[ ]	Grooming	[ ]
Bending	[ ]	Eating	[ ]
Lifting	[ ]	Cleaning	[ ]
Sitting	[ ]	Driving	[ ]
Standing	[ ]		
Throwing	[ ]		
Reaching overhead	[ ]		

Other: _____ Sports Activities: _____

_____ _____

Patient Name Date