LoDo Physical Therapy, PLLC

Referred by Another Patient?

Tell us who!

_____

Patient Name:_____ Date of Birth:_____

Address:_____ Last 4 of SSN: ***** - _____

City:_____ State: _____ Zip:_____ Age: _____ Sex: **M** **F**

Home Phone #:_____

Cell Phone #:_____ Have you received physical therapy elsewhere this year?

Email Address:_____ **Yes** **No**

Please note: It is your responsibility as the patient to know your own insurance benefits. We are in no way responsible for any denial or non-payment of services.

INSURANCE INFORMATION

Insurance Company:_____ Member ID: _____

Yearly Deductible: _____ Has it been met? _____ Plan Year:_____

Copay: $_____ Coinsurance: _____ % OOP:_____

REFERRING PHYSICIAN INFORMATION

Primary Care Physician: _____ Phone #: _____

Hospital/Clinic Name: _____ Fax #: _____

I authorize the release of any private health information necessary to process claims at Lodo Physical Therapy, PLLC.

I agree, whether signing as agent or as patient, that in consideration of the services rendered to the patient, to be individually obligated to pay the bill. Should the account be referred to an attorney for collection, I shall pay reasonable attorney's fees.

I hereby assign payment directly to LoDo Physical Therapy, PLLC, BASIC BENEFITS and/or MAJOR MEDICAL (catastrophe) BENEFITS herein specified and otherwise payable to me but not to exceed the regular charges for this period of treatment.

I understand I am financially responsible for any charges not covered by my insurance.

I understand that upon discharge I may submit a request, in writing, a copy of my digital records.

_____ _____

Patient or Guardian Signature Date

LoDo Physical Therapy, PLLC

PATIENT MEDICAL HISTORY FORM

Name _____ **What are we seeing you for?** _____

To ensure that you receive a thorough and complete evaluation, please provide us with important background information on this form. If you are unclear regarding any of these questions, please leave it blank and your therapist will be happy to assist you.

Do you have now or have you ever had any of the following medical conditions? Please circle yes or no.

Heart problems / Pacemaker	**YES**	**NO**	History of falls	**YES**	**NO**
Lung problems	**YES**	**NO**	Arthritis	**YES**	**NO**
Diabetes	**YES**	**NO**	Osteoporosis / Osteopenia	**YES**	**NO**
Cancer	**YES**	**NO**	Difficulty breathing	**YES**	**NO**
High blood pressure	**YES**	**NO**	Difficulty swallowing	**YES**	**NO**
Asthma	**YES**	**NO**	Dizziness	**YES**	**NO**
Blood disorders	**YES**	**NO**	History of drop attacks/fainting	**YES**	**NO**
Hepatitis	**YES**	**NO**	Seizures	**YES**	**NO**
HIV	**YES**	**NO**	Unexplained recent weight loss	**YES**	**NO**
Tuberculosis	**YES**	**NO**	Circulation problems	**YES**	**NO**

Do you currently have or have you had any of the following symptoms related to your injury?

Arm/Leg Swelling	**YES**	**NO**	Joint/Muscle Swelling	**YES**	**NO**	Problems sleeping	**YES**	**NO**
Constipation/Diarrhea	**YES**	**NO**	Nausea/Vomiting	**YES**	**NO**	Problems urinating	**YES**	**NO**
Fever/Chills/Sweats	**YES**	**NO**	Numbness/Tingling	**YES**	**NO**	Unusual fatigue	**YES**	**NO**

Please list your current level of pain using a scale of 0 - 10 (0 = no pain, 10 = unbearable pain)

At best _____ / 10 Current _____ / 10 At worst _____ / 10

Please list / describe any surgical procedures and/ or significant injuries for which you have been treated. Please include approximate dates. _____

_____

List all medications you are currently taking (prescriptions, over the counter, pills, injections, patches, vitamins, and herbs): _____

_____

List all allergies (medications, food intolerances, latex, etc.):_____

_____

Please list any other types of healthcare providers you are currently receiving care from (including physician, chiropractor, massage therapist, acupuncturist, etc.): _____

OFFICE POLICIES

☐ **CANCELATION POLICY:**

- **If you must cancel an appointment, 24-hour notice is required.**
  - For Monday scheduling, notice by Friday at 5 pm is required to cancel with no penalty.
- **If you cancel with less than 24-hour notice,** we reserve the right to charge a minimum fee of $25.00, up to a maximum fee of a full appointment cost of $90.00.

☐ **NO-SHOW POLICY:**

- Failing to show for your appointment without contacting our office constitutes a **"NO SHOW"**.
  - You will be responsible for your full visit rate, at $90.00.
  - This cannot be billed to your insurance company.

☐ **LATE POLICY:**

- If you arrive more than 10 minutes late for your consultation, your time WILL be reduced. We will not extend your time into the next consultation.

☐ **FAMILY & FRIENDS:**

- We do not allow appointment switches (even between family members or friends) without the prior consent of our office within 24 hours of a consultation; our $25.00 cancel fee policy will still apply.

☐ **HEALTH INSURANCE:**

- **I understand that my insurance benefits reviewed by Lodo P.T. are never a guarantee of coverage.**
  - I agree to pay in full any and all charges not covered by insurance or other benefits.
  - I understand that it is unlawful (and a breach of contract with "in-network" insurance companies) for LoDo Physical Therapy, PLLC to waive copays, coinsurances, and deductibles that are my responsibility.
  - If your insurance policy has changed, you have 48 hours (2 business days) following your date of service to notify us of such a change, otherwise be subject to our full rate (up to $200).

☐ **FINANCIAL:**

- A $25.00 fee will be added to my account for any returned check. If I do not pay my outstanding balance within 60 calendar days, my balance may be sent to a collection agency and a 1.5% fee will be added to the unpaid balance monthly.
- If a form of payment is on file, we reserve the right to apply it to any open balances. If your account holds a credit, we will return your overage at the end of your treatment. If there is a credit on file, we reserve the right to apply it to any open balances.

☐ **3RD PARTY ADMINISTRATORS:**

- If your insurance policy is managed by a 3rd party, we will submit necessary documentation for approval of visits. Upon the first denial, submissions beyond that will be at the provider's discretion of either 12-15 visits, or 45 days wait period. These policies do NOT cover maintenance treatment. We are committed to working within the parameters that are laid out by our contracts with insurance companies.

My initials and signature on this page is acknowledgement & adherence of the policies of Lodo Physical Therapy, PLLC.

_____ _____

Patient/Guardian Signature Date

LoDo Physical Therapy Consent & Privacy Notice

CONSENT: I consent to physical therapy services at LoDo Physical Therapy, PLLC (LPT). I know if I have any questions about my care, I should be sure to ask the physical therapist about them. I know it is up to me to inform the physical therapist about any health problems or allergies I have. I must also tell the physical therapist about drugs or medications I am taking.

NO GUARANTEES: I understand that the practice of physical therapy is not an exact science and that no guarantees or promises have been made to me as a result of treatments or examinations by the physical therapist. I understand that no contract, warranty, guarantee, or promise concerning the results of the physical therapy services is made. This consent to treatment form is not a contract, nor is it an offer to contract, nor is it an acceptance of an offer to contract.

NOTICE OF PRIVACY PRACTICE: I have read the *Lodo Physical Therapy Statement of Privacy Notice* (below) within this packet and I understand that a copy of the notice will be provided to me upon my request.

LoDo Physical Therapy Statement of Privacy Notice

•We may disclose your protected health care information (PHI) 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 law enforcement officials 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 (303) 515-2500.
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 (303) 515-2500. 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 LoDo Physical Therapy, PLLC with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice. Please contact Phil Koffler, Owner of LoDo Physical Therapy, at 303-515-2500 if you have any questions regarding our policies with your Protected Health Information. I certify that any and all information provided by me is true. I have read the information on this form. It has been fully explained to me, if needed, and all of my questions have been answered.

_____ _____

Patient or Guardian Signature Date

Trigger Point Dry Needling (TDN) Consent Form

Trigger-point Dry Needling involves placing a small needle into the muscle at the trigger point in order to cause the muscle to contract and then release, improving the flexibility of the muscle and therefore decreasing the symptoms.

TDN is a valuable treatment for musculoskeletal pain. Like any treatment, there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving consent to treatment.

Possible Risks of the Procedure:

Though unlikely there are risks associated with this treatment. The most serious risk associated with TDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and in skilled hands should not be a concern.

Other risks may include bruising, infection and nerve injury. Please notify your provider if you have any conditions that can be transferred by blood. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and does not have a cutting edge, the likelihood of any significant tissue trauma from TDN is unlikely.

Please consult with your practitioner if you have any questions regarding the treatment above.

Do you have any known diseases or infections that can or may be transmitted through bodily fluids?

YES **NO**

If you marked yes, please discuss with your practitioner.

_____ _____

Client/Guardian Signature Date

☐ ***By checking this box, I acknowledge that there will be a $5.00 equipment charge, per session, for dry needling.***

LoDo Physical Therapy, PLLC

REQUIRED FORM

Insurance Verification Form

Patient Name:_____ **Appointment Date:**_____

This form is required to be filled out and signed in order to be seen by any practitioner at LoDo Physical Therapy.
We cannot guarantee any benefit or payment. We collect payment at time of service based on information obtained from insurance companies. We will not be responsible for non-coverage given to us by said parties.

What kind of insurance will we be billing?	___ Health ___ None (Self - Pay) ___ Auto Accident** ___ Work Comp***
Insurance Company: ___ BCBS ___ UHC ___ Humana	3rd Party Administrator: ___ Optum Health ___ OrthoNet
ID #:	Group #:

Auto Accident / Workers Comp*** Information**

Insurance Company:	*Phone:*	*Rx? Yes No*
Claim Adjuster:	*Claim #:*	

PRIMARY HEALTH INSURANCE INFORMATION *(required)*

Policy Holder: Self Spouse Child Partner			*Notes*
Plan Effective Date:		**Patient Responsibility Per Visit** **$**	
Deductible (DED):			
Is DED Met? **Yes** **No**		Copay: $	
Does DED Apply? **Yes** **No**		Coinsurance: %	Is pre-authorization required for this group/policy? **Yes** **No**
Out of Pocket Max (OOP):		Visits Allowed:	
Has it been met? **Yes** **No**		Visits Used:	

SECONDARY INSURANCE INFORMATION *(If Applicable)*

Insurance Company:	ID #:	Group #:
Policy Holder Name: Self Spouse Child Partner		

____ I acknowledge my responsibility for any outstanding costs not covered by a secondary insurance provider.

Your signature below is your acknowledgement that you have read the opening statement at the top of this page, and that you further understand that this is NOT a guarantee of benefits. I recognize that actual benefits will be determined by my insurance company once a claim has been received.

_____ _____

Patient or Guardian Signature Date