IMG PHYSICAL THERAPY

805 N RICHMOND STREET, SUITE 103, FLEETWOOD, PA 19522

PHONE: 610-944-8140 FAX: 610-944-8190 IMGPT.COM

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General Office Information

Welcome to Integrated Medical Group Physical Therapy (IMG-PT). We look forward to serving your physical therapy needs and wish you a speedy recovery.

Cancellation Policy: Appointment times are reserved exclusively for you. If you are unable to keep an appointment, we request a phone call as early as possible to allow us time to offer that appointment to someone else. We do understand that extenuating circumstances sometimes occur for missing an appointment. We simply request that you call and notify the office in order not to be charged for a missed appointment.

No-Show Policy: If you No-Show for a visit without a courtesy call for the reason of your cancellation you will be charged $25 for the missed appointment. Two (2) No-show appointments in a row or three (3) total No-shows will result in you being discharged from the office and all future visits being cancelled. This No-Show Policy does not affect Cancellations where you call to notify us that you will not be attending your visit(s). You will only be charged if you do not attend your visit and do not have the courtesy to notify us on why you will not be attending. Patient Initials ___________ Employee Initials_______________

Authorization for Release: I hereby authorize IMG-PT to release any information concerning my care to the appropriate individuals of insurance companies and physicians. I accept full responsibility for any deductibles and co-insurance, or any amount not covered by my insurance company for service rendered to me by this facility. I authorize payment of medical benefits to IMG-PT.

Treatment Consent Authorization: I am fully aware of my medical and physical therapy diagnosis and I give my consent to IMG-PT to provide treatment for my condition.

Medicare, Medicaid, Federally Funded, Private, Auto, and Work-Comp Signature on File: I authorize payment of my Physical Therapy Benefits to IMG-PT for services rendered.

Notice of Privacy Practices: I have received a copy of IMG-PT's Notice of Privacy Practices.

Signature:____ Date:__________________________

IMGPC PHYSICAL THERAPY

Patient Information Form (please print neatly)

PATIENT INFORMATION

Patient's Full Name:______________________________ Home Phone#______________________

Mailing Address:______________________________ Work Phone#______________________

City, State, Zip______________________________ Cell Phone#______________________

Birth Date:____________ SS#____________________ [ ] Male [ ] Female Marital Status: M S W D Separated

E-mail______________________________ Would you like to receive our monthly newsletter? Y N

****Emergency Contact Name**____________________ Phone____________________ Relationship to patient__________

*****If patient is a minor Emergency Contact information must be completed by parent or guardian*****

Work Related: [ ] No [ ] Yes if yes; DOI____________ Claim#________________ Employer______________
Contact Person Name/Phone#____

MVA or Personal Injury: [ ] No [ ] Yes if yes; Attorney's name/phone# ______________________________
Were you the driver? [ ] Yes [ ] No Claim#____________________ DOI____________________

PRIMARY HEALTH INSURANCE INFORMATION

Insurance Company Name:____
Address:______________________________ Phone#______________________
Policy Holder's Name:______________________________ Policy Holder Birth Date:______________________
Policy Holder's SS#:______________________________ Relationship to patient:______________________
Policy ID#______________________________ Group#______________________

If there is a secondary insurance please complete the following:

Insurance Company Name:____
Address:______________________________ Phone#______________________
Policy Holder's Name:______________________________ Policy Holder Birth Date:______________________
Policy Holder's SS#:______________________________ Relationship to patient:______________________
Policy ID#______________________________ Group#______________________

I consent to examination, treatment and procedures which may be performed during physical therapy, including emergency treatment considered necessary by the therapist. I authorize IMG Physical Therapy to release any information acquired in the course of examination or treatment for insurance purposes. I assign payment directly to IMG Physical Therapy for services covered by insurance. I understand that I am personally responsible for all charges. I also understand that I am responsible for payment of reasonable attorney's fees and collection expenses, if required, for the collection of this account.

____

Signature of Patient or authorized person's signature (parent, legal guardian, etc) **Today's Date**

****PLEASE NOTE:** Our office is not responsible for charges incurred if updated insurance information is not provided by patient.

PATIENT MEDICAL HISTORY **PLEASE ANSWER ALL QUESTIONS** **IMGPC PHYSICAL THERAPY**

PATIENT NAME:______________________________ DATE OF BIRTH:______________

REFERRING PHYSICIAN:______________________________ AREA TREATING:______________

NEXT APPT WITH REFERRING PHYSICIAN?______________ DATE OF ONSET OF PAIN:______________

HAVE YOU HAD THESE SYMPTOMS BEFORE? Y N BEEN TREATED WITH PREVIOUS THERAPY FOR THIS CONDITION? Y N

HAVE YOU HAD RELATED SURGERY? Y N DATE OF SURGERY:______________

PICK APPROPRIATE BOXES RELATED TO YOUR CURRENT CONDITION:

WORK RELATED ☐ Date__________ ATHLETIC/RECREATIONAL INJURY ☐ INJURY FROM FALLING ☐

MOTOR VEHICLE ☐ Date__________ REOCCURRENCE OF PAST INJURY ☐ CAUSE UNKNOWN ☐

EMPLOYER:______________________________ OCCUPATION:______________

ARE YOU CURRENTLY WORKING? Y N IF NOT, LAST DAY WORKED?______________

HOW DID YOU HEAR ABOUT IMG PHYSICAL THERAPY **(Circle or Check)** ? ☐ Online / Website / Facebook ☐ Workshop ☐ Friend / Family ☐ Past Patient ☐ Doctor ☐ Insurance Company ☐ Advertisement ☐ Other ______________

DO YOU HAVE OR HAD ANY OF THE FOLLOWING?

ANGINA/CHEST PAINS	☐	POOR TOLERANCE TO COLD OR HEAT	☐	DIFFICULTY SLEEPING	☐
HIGH BLOOD PRESSURE/HTN	☐	PAIN WITH COUGHING OR SNEEZING	☐	TUMORS / CANCER	☐
HEART DISEASE/HEART ATTACK	☐	BOWEL AND BLADDER ABNORMALITIES	☐	UNEXPLAINED WEIGHT LOSS	☐
HEART PALPITATIONS	☐	UNUSUAL FATIGUE OR WEAKNESS	☐	CONSTANT PAIN UNRELIEVED	
PACEMAKER / HEART SURGERY	☐	TINGLING / NUMBNESS / LOSS OF FEELING	☐	BY REST OR MOVEMENT	☐
CIRCULATORY PROBLEMS	☐	BALANCE PROBLEMS / HISTORY OF FALLS	☐	RINGING IN YOUR EARS	☐
STROKES	☐	MUSCULAR PAIN AT REST	☐	HEADACHES	☐
ASTHMA/BREATHING DIFFICULTIES	☐	MUSCULAR PAIN WITH EXERTION	☐	TREMORS	☐
SHORTNESS OF BREATH	☐	BACK INJURIES	☐	BLURRED/DOUBLE VISION	☐
LUNG DISEASE	☐	ARTHRITIS	☐	DIZZINESS & FAINTING	☐
LIVER/GALLBLADDER PROBLEMS	☐	OSTEOPOROSIS	☐	JAW INJURIES/TMJ	☐
HERNIA	☐	RHEUMATOID ARTHRITIS	☐	NECK INJURIES	☐
DIABETES	☐	DISLOCATIONS (JOINTS)	☐	GOUT	☐
HYPOGLYCEMIA	☐	JOINT SPRAINS	☐	SEIZURES	☐
KIDNEY PROBLEMS	☐	METAL IMPLANT	☐	SKIN ABNORMALITIES	☐
NAUSEA/VOMITING	☐	SEXUAL DYSFUNCTIONS	☐	ALLERGIES	☐
SMOKING	☐	DEPRESSION / BIPOLAR / ANXIETY ISSUES	☐	LATEX ALLERGY	☐
SURGERIES (PLEASE LOOK BELOW)	☐	ARE YOU PREGNANT? Y N			

PLEASE LIST ANY SURGERIES AND HOSPITALIZATIONS:______________________________

OVER

PATIENT MEDICAL HISTORY **IMGPC PHYSICAL THERAPY**

PLEASE LIST ALL MEDICATIONS THAT YOU ARE PRESENTLY TAKING:

ARE YOU ALLERGIC TO ANY MEDICATIONS? Y N IF YES, PLEASE LIST:

PLEASE MARK THE FOLLOWING, IF ANY OF THESE, DIAGNOSTIC TESTS THAT HAVE BEEN PERFORMED?

X-RAYS/BONE SCAN	DATE:________	RESULTS:________
MRI	DATE:________	RESULTS:________
CAT SCAN	DATE:________	RESULTS:________
EMG/NCV	DATE:________	RESULTS:________

PLEASE DESCRIBE YOUR PROBLEM:________

PLEASE CHECK THE FOLLOWING WHICH BEST DESCRIBES YOUR PAIN

CONSTANT ☐	INCREASING ☐	NIGHT PAIN ☐	DULL/ACHY PAIN ☐	SHARP PAIN ☐
INTERMITTENT ☐	DECREASING ☐	STIFFNESS ☐	PAIN UPON WAKING ☐	OCCASIONAL ☐

PAIN IS AGGRAVATED BY:________

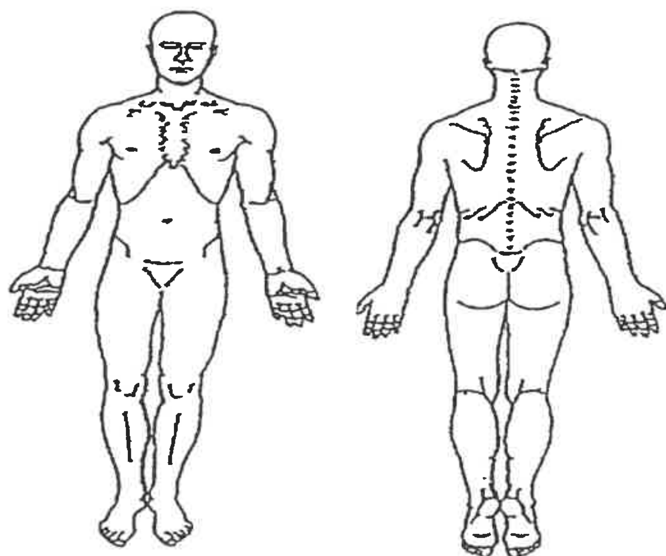
PAIN IS EASED BY:________

HAVE YOU BEEN TREATED BY A **PHYSICAL THERAPIST**? Y N **CHIROPRACTOR** Y N
WHAT WERE YOU TREATED FOR?________
WHERE WERE YOU TREATED?________ WAS IT HELPFUL________

WHAT IS YOUR GOAL FOR PHYSICAL THERAPY?________

AT THE PRESENT TIME, WOULD YOU SAY THAT YOUR HEALTH IS: EXCELLENT – VERY GOOD – FAIR – POOR
(Please circle)

PLEASE CIRCLE THE AREA THAT HURTS



I, THE UNDERSIGNED, STATE THAT I HAVE ANSWERED THIS QUESTIONAIRE TO THE BEST OF MY KNOWLEDGE AND I CONSENT TO RECEIVE AN EVALUATION AND TREATMENT FROM IMG-PT.

____
SIGNATURE **DATE**

____
GUARDIAN IF PATIENT IS UNDER 18 **DATE**

____
THERAPIST SIGNATURE **DATE**

IMGPC PHYSICAL THERAPY
805 North Richmond Street, Suite #103
Fleetwood, PA 19522
610-944-8140

Notice of Privacy Practices

To our patients. This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Worker's Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals

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involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request: however, if we do agree, we are bound by your agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to *IMGPC Physical Therapy.*
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to *IMGPC Physical Therapy*. You must provide us with a reason that supports your request for the amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of the Notice at any time. To obtain a copy of this notice, contact IMGPC Physical Therapy.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, *contact the office manager at IMGPC Physical Therapy*. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact IMGPC Physical Therapy.

I hereby acknowledge that I have been presented with a copy of IMGPC Physical Therapy Notice of Privacy Practice.

____________________	____________________	____________________
Print Name	**Signature**	**Date**

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Patient Copy

Integrated Medical Group-Physical Therapy (IMG-PT)

Financial Policy

Patient Name:__________________________________ **Date:**________________

We are pleased and honored that your and/or your referring physician have trusted us with your care. We hope that after your first visit you will feel valued and well taken care of. Physical Therapy is a tool, a pathway to get you to your goals. Our highly trained staff members at IMG-PT strive to do their best to make your experience pleasant. As part of this relationship, we wish to review expectations of your financial responsibility as outlined in our Financial Policy.

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY

- **Insurance benefits are checked by IMG-PT as a courtesy to the patient.** Please provide insurance cards upon first visit to ensure that claims are submitted promptly. All co-payments are due at the time of service. For deductible plans- if you owe more than $500 towards your deducible and do not have an HSA or HRA, we will collect $50 each visit and balance bill you the remainder. Co-insurances and fees not covered by your insurance policy will be billed to you upon receipt of insurance remittance. If you cannot pay upfront, the billing department may be able to work with you to set up a payment plan. In the rare case the insurance denies claims because information needs to be verified by you, the balance will be shifted to you until the issue is resolved with your insurance company. If you are unwilling to call the insurance company to give the required information, you will be responsible for the entire amount of the bill.
- It is important to understand that **the patient is under contract with their own insurance company.** The amount owed to the provider (IMG-PT) **is never determined by IMG-PT.** This includes unmet deductibles, co-pays, or co-insurances. In general, it is not acceptable for a patient not to pay the amount owed to the provider (IMG-PT) because it is a breach of the contract with the patient's insurance company. In addition, IMG-PT is in contract (in network) with most insurance companies and therefore, where applicable, will write off anything over what is allowable by contract. Billing is done on a daily basis to all insurance companies. If payment is not received or refused your insurance company could be notified.
- **Please do not ask the billing department to adjust off any charges, deductibles or co-pays over what is allowed by insurance as it is generally not permitted for them to do so.** It is VERY important for the patient to take responsibility in knowing his/her individual benefits and what insurance will allow so unexpected balances do not occur. **The IMG-PT Billing Department files with many insurance's and most offer several different plans, therefore it is the patient who must make sure the benefits checked are what match their plan.**
- In the case the patient needs a service that is not covered by the in network agreement, IMG-PT will notify the patient to see if the patient agrees to the service. The billing department will then make arrangements to charge and bill the patient accordingly.
- If you do not have In-Network Medical Insurance, please speak with our office to discuss self-pay options. **Please note: There is no payment plan option for our self pay patients.**
- **Third Party/Workers Comp/MVA Patients:** We are happy to see personal injury or motor vehicle accident patients. The billing department will need information such as claim number, adjuster's name and contact phone number and mailing address. Should the Third Party/Workers Comp or MVA company deny our claims; the claims will be submitted to your Medical Insurance or become your responsibility. **Please let us know if you have an attorney involved along with his/her name and phone number.**

Integrated Medical Group-Physical Therapy (IMG-PT)

Patient Copy

Financial Policy

- **Payment/co-pay is due at the time of service** unless prior arrangements have been made.
- **Minors and Dependents:** Parents and guardians are responsible for payment for their dependents at the time service is rendered.
- Billing statements are sent to patient with a personal balance on a monthly basis. We ask that upon receipt of such a statement, payment is brought to our office or sent to our billing department within fifteen (15) days of receipt. If you have a financial hardship or you are unable to pay the balance in its entirety, please contact our billing coordinator to discuss payment options. **If your account becomes delinquent and you have not established or met payment options with our billing office, your account will be turned over to our outside collection agency and your account will be assessed additional collection fees.**
- If your check is returned for insufficient funds, you will be charged a returned check fee of $30.
- If you request the completion of medical forms, you may be charged a fee.

Helpful Definitions

When you come into the financial office or even reading your Explanation of Benefits from our insurance company, often times there are terms that are used that you may not understand. Below we have provided sample definitions of these terms for you in hopes that this will help you better understand some of your coverage. (Note that your insurance company may define these terms differently.)

Deductible:
The amount you owe for covered health care services before your health insurance or plan begins to pay. For example, if your deductible is $2,000, your plan won't pay anything until you have met your $2,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

Co-insurance:
Your share of the costs of a covered health care service, calculated as a percent (for example 20%) of the allowed amount for the service. You pay co-insurance plus any deductible you owe. For example, if the health insurance or plan's amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Co-payment:
Co-pay is the set fee for a particular service that is determined by the patient's medical insurance policy. For example, if you have a $15 co-pay for physical therapy, then you pay $15 each visit.

Out of Pocket Max:
The out of pocket max (OOP) is a cap on how much the patient has to pay for the individual or family covered medical expenses each year. After the OOP max is met, the insurance plan pays 100% of all remaining covered expenses for that year.

We look forward to providing you with World Class physical therapy services!!!