DANIEL B. NEFF, DPT PHYSICAL THERAPY

Patient Name: _____ Birthdate: _____

Authorized Person (If patient is a minor): _____Birthdate: _____

Address: _____ City: _____ St: _____ Zip: _____

Phone: _____ Email: _____ Physician: _____

CONSENT FOR TREATMENT

During the course of treatment, you may experience an increase in your symptoms. In most circumstances this is a normal part of the recovery process. It is important for you to inform the clinical staff of any difficulties that you are experiencing. You may contact this facility at any time to discuss your status. If you believe that what you are experiencing is urgent or out of the ordinary, please contact your physician. Please remember that your care is our top priority. We want to provide you with as much information and education that we can to help expedite your recovery. In the case of a minor patient (under the age of 18) I hereby authorize Daniel B. Neff, DPT Physical Therapy to administer physical therapy care deemed necessary for the course of treatment when I am unable to accompany my son/daughter for treatment. I understand the risks involved in physical therapy and agree to fully cooperate and to participate in all physical therapy procedures and to comply with the established plan of care.

Daniel B. Neff, DPT Physical Therapy will bill the insurance provided by you, the patient, at your initial evaluation. By signing this form, you are indicating that the treatment being provided is not due to an auto accident, workers compensation claim, or any other accident.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE ACT

My signature below indicates that the Notice of Privacy Practices Act has been posted by Neff Physical Therapy for patients to review. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Neff Physical Therapy to release any of my protected healthcare information. This document will be signed annually unless otherwise specified by patient.

Signature of Patient or Authorized Delegate: _____

Date: _____

FINANCIAL INFORMATION FOR NEFF PHYSICAL THERAPY

Primary Insurance: _____ Secondary Insurance: _____

Patient: Please remember that we are not your insurance agent or an insurance specialist. We will help you to the best of our ability but will not be held accountable for any assistance. We have limited information concerning your insurance. We encourage you to call your insurance company to understand your outpatient physical therapy benefits. We will file a claim to your insurance company as a courtesy to you. Any patient having a secondary insurance, may have to submit their own claims if we do not have access to that insurance plan. We do not participate with any Medicaid programs, please advise our staff if you have a Medicaid product. Please be aware that most insurance's now need authorization. Patient's that need continued treatment after the initial authorization is used, may have to wait for a response from their insurance before we know if the requested additional visits are authorized. Should you, the patient, want to continue treatment without notification of additional visits being authorized, understand by signing this document that it may become your responsibility should the insurance not grant the additional authorized visits. Please ask Neff PT for specifics on your authorization and/or call your insurance company concerning any questions on your Physical Therapy authorization. Should your insurance company deem your treatment not medically necessary, you the patient may have some patient responsibility. Some insurance companies have visit limits. If you go over your visit limit for the year, we will charge you a fee for all your physical therapy after the visit limit has been exhausted. Please ask Neff PT for specifics. Any refunds under $5 will be credited to your next visit unless otherwise specified.

PAYMENTS

All copays are due at the time of service.

We collect an estimated cost each visit to go toward your deductible. Be advised these are *estimates* and you may owe more, or less once we get notification from your insurance. Should you owe more we will notify you of the remaining balance. Should you owe less, we will reimburse you once we have received all notifications from your insurance.

Please sign and date below that you have read and understand this document. Signatures are annual unless otherwise specified by patients.

Signature: _____Date: _____

AUTHORIZATION FOR THE RELEASE OF INFORMATION

1) Patient's Printed Name: _____

2) Daniel B. Neff, DPT Physical Therapy will only disclose the protected health information you want disclosed/released. I only authorize the release of information to the following person/entities: (please note all information will go to your referring doctor and/or insurance when warranted) Examples: Spouse, Parent, Friend, Other, Special requests.

   1._____ 2. _____ 3. _____

3) I understand that I can refuse to give authorization without fear of retaliation or treatment limitations. I understand that if I give authorization, I may revoke it at any time by notifying Neff Physical Therapy in writing. I understand that the information used/disclosed as a result of my authorization may be subject to re-disclosure by the recipient and may not be protected by Federal privacy regulations once in the recipient's possession. I understand if Neff Physical Therapy requests my authorization it is required to tell me the purpose and whom my PHI (protected health information) is being released to. I understand that I will receive a copy of this authorization if I request it. Neff Physical Therapy will not be compensated for using or disclosing my PHI unless related to treatment or payment procedures unless specific permission is obtained by the patient after full disclosure of purpose & intent.
   Medicare Patients Only: I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Daniel B. Neff, DPT Physical Therapy for services furnished to me by that physical therapist. I authorize with my signature any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If other health insurance coverage is indicated on the HFCA-1500 my signature authorizes releasing of the information to the insurer or agency. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of Medicare as the full charge and the patient is responsible for the deductible, co-insurance or non-covered services. Co-insurance and deductibles are determined by Medicare. I also attest that if I am receiving home healthcare, which may result in patient responsibility.

My signature below indicates that I have read and understand this document. Forms will be updated annually unless otherwise specified by the patient in writing.

Signature of Patient or Authorized Delegate: _____ Date: _____

DANIEL B. NEFF, DPT PHYSICAL THERAPY MEDICAL HISTORY

Patient Name: _____ DOB: _____ Date: _____

Family Physician: _____

Auto Claim: Y N

Workers Comp Claim: Y N

Accident Claim: Y N

Medicaid: Y N

****We do not participate** with auto, workers comp, or any Medicaid product.** You will have to see another provider that accepts these products.

Please circle any that apply to your Medical History:

High Blood Pressure **Heart Disease** **Numbness** **Pacemaker** **Cancer**

Shortness of Breath **Female Issues** **Weakness** **Pregnant** **Night Pain** **Stroke**

Diabetes **Dizziness** **Headaches** **Irregular Heart Rate** **Fatigue** **Osteoporosis**

List any other Medical History/Surgeries: _____

_____

Have you fallen in the past year? **Y N**

Medications: _____

General Health: (circle one) **Poor** **Fair** **Good** **Excellent**

In the past 3 months have you experienced any significant changes in health? (Physical or Mental): _____

CURRENT COMPLAINT

Current Complaint: _____

How did it start? _____

Does your pain radiate: **Y** **N** Where: _____ Pain Level: (0 – 10) _____

Surgical Date if Applicable: _____ Surgeon: _____

Restrictions: **Y** **N** _____ Diagnostics Tests: _____