MANUAL SOLUTIONS
PHYSICAL THERAPY

Patient Information Form

First Name Middle Name Last Name Male/Female

Address City State Zip Code

Date of Birth Preferred phone Secondary Phone

Email Address Marital Status

Employer Occupation Work Phone

Emergency Contact Name Phone number

How did you hear about us (circle one): Doctor, friend_________________, or other _________________

Insurance Information

Primary Insurance:

Insurance Name ID/Claim# Policy Holder

Secondary Insurance:

Insurance Name ID/Claim# Policy Holder

If filing Workers Compensation or Auto Injury:

___________________ <u>Work Related</u> <u>Accident Related</u>

Date of Injury Yes No Yes No

Referring Doctor Date of Last Visit How Injury Occured

HIPAA

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: ___________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.**

Please **print** name of Patient

Please **sign** for Patient/Guardian of Patient

Legal Representative/Guardian

Relationship of Legal Representative/Guardian

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

☐ First Name Only ☐ Other______________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents, and any care takers who can have access to this patient's records):

Name: ____________________________ Relationship: ____________________________

Name: ____________________________ Relationship: ____________________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

Please Read and initial below

Manual Physical Therapy Examination:
For muscle and bone problems it is necessary for the Physical Therapist to do a "MANUAL PHYSICAL THERAPY EXAMINATION." This involves your bare skin in a firm but gentle manner. The Physical Therapist is feeling for the bony landmarks just under the surface of your skin. In some cases, this will involve the buttocks and pubic areas. The position of the landmarks tells the Physical Therapist clues on how to help solve your problem.

Great care and concern is taken to observe and protect your modesty. If you desire, another person will be present during this examination. If you are uncomfortable, please make it known to the Physical Therapist. If you would like a demonstration on a model skeleton, please inquire.

I acknowledge that I have read the information above; it has been explained to me. Furthermore I understand the extent of the manual physical therapy examination to be performed. By my signature consent to have the "MANUAL PHYSICAL THERAPY EXAMINATION."
___________ (initial)

Acknowledgement to Release Information to Medical Practitioners:
In order to best integrate your care with other medical professionals, Manual Solutions Physical Therapy often needs to communicate with your physician, chiropractor, dentist, or other practitioners. We are required to have your consent to do this. By initialing below, you are giving us permission to communicate with other professionals about your care. Communications will be limited to information that is specifically related to the coordination of care. You have the right to limit or rescind your consent at any time. If this is the case, we ask that you provide us with a statement identifying specifically what you would or would not like us to do.
___________ (initial)

Authorization to Release Copies of Medical/ Billing Records:
I, the patient, or legally authorized representative request Manual Solutions Physical Therapy to release my protected health information, including medical and billing records to myself. I understand that I will need to personally sign and submit a new release of records (which will be provided to me upon request) should I find it necessary for another person(s) or company/organizations to obtain these protected records.
___________ (initials)

Financial Policy

The following information outlines the financial policy of Manual Solutions Physical Therapy PLLC. All patients and or beneficiaries must read and understand all sections before being seen by any provider.

We have instituted the following policies. These policies allow us to avoid passing increased operational costs on to you, our patient. Please familiarize yourself with our policy and initial each to confirm you have read them.

_______ The Ultimate responsibility for your medical bill incurred at our practice lies with you, our patient, not your insurance, or third-party payer.

_______ We understand that you may need to cancel or reschedule an appointment. If you are unable to keep your appointment, please notify our office as soon as possible. This will help us shorten the waiting period for our patients. Any patient that misses an appointment without 24 hours' notice of cancellation will be charged $35 which must be paid before your next visit.

_______ Your Copays, deductibles or percentages are due at the time of service. We will file your insurance claims for you, however, you are responsible for all charges regardless of coverage.

_______ Any account with an unpaid balance older than 30 days will be charged a $15 monthly fee.

_______ Patients are not permitted to run a personal balance of more than $175 without a prearranged payment plan. A balance of more than $175 may result in a patient being unable to schedule future appointments or be seen for previously scheduled appointments until balance is paid down.

_______ All Medicaid/Medicare recipients must present their Medicaid/Medicare card at the time of service. All Medicaid/Medicare recipients must see their provider first and obtain a referral (Healthy Connections for Medicaid) before being seen by Manual Solutions Physical Therapy. Patients that do not have a referral will be considered to have no insurance and will be responsible for the down payment of $80 and will be responsible for any remaining balances.

_______ If we are billing your insurance and your deductible has not been met you will be responsible for the down payment of $80 and will be responsible for any remaining balances.

For Those who have made financial arrangements, monthly payments are required to keep an account current regardless of insurance coverage.
A $25 charge will be added to accounts for returned checks.

ANY ACCOUNT TURNED OVER FOR COLLECTIONS WILL BE ASSESSED A 50% RECOVERY FEE.

As a courtesy to you, we will bill your primary and secondary insurance carriers only. If you have a third insurance, you need to submit any and all claims to them. Our physicians are contracted with Medicare, Medicaid, Blue Cross, Blue Shield, First Health, Cigna, and many other insurance companies. It is *ultimately your responsibility to make sure we are a participating provider for your insurance company and to give correct insurance information to us in a timely manner for billing purposes.*

Please feel free to discuss any questions or concerns you may have with the billing staff. We will be happy to assist you and if necessary, assist in making payments arrangements.

I have read and agree to the above outlined financial policy of Manual Solutions Physical Therapy. *Disagreeing with this policy does not change the policy. The policy will be enforced if the patient is seen by the doctor physician assistant.* I agree that I am ultimately responsible for any charges incurred at Manual Solutions Physical Therapy.

Signature________________________________**Print Name**______________________________

Payment Options

Our Billing rates are approximately $295 for a new evaluation and approximately $150 for follow up visits, depending on the treatment given. We offer a discount when the bill is settled at the time of service and therefore does not go through billing. With this discount, new evaluations are $100 and follow up visits are $80. When settled at the time of service with the discounted rate, the date of service is closed, and no more action can or will be taken on it. You may not bill your own insurance company for that claim. We have contracts with insurance companies that require a uniform fee schedule. If we bill out, the billing amount is the same whether it goes to the patient or to the insurance company. If the claim is closed out the day of service, we offer a discount, which is available to insurance companies as well as patients. To be eligible for the discounted rate, payment must be made the day of service.

Option 1:

I am choosing Manual Solutions to bill my insurance company. I understand that the billing rates are higher, and I may be responsible for the full amount billed, depending on my insurance benefits.

Private Insurance Authorization for Assignment of Benefits/Information Release:
I, the undersigned, authorize payment of medical benefits to Manual Solutions Physical Therapy for any services to me by the physical therapy. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company, or their agent, information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims or benefits.

Signature: ________________________________ **Date:** ____________________

Printed Name: ____

Option 2:

I am choosing the time of service discounted option. I understand that no further action can or will be taken on the claim with this option. I understand that this payment option will not apply towards my insurance deductible, and I cannot send claims in to my insurance company.

Signature: ________________________________ **Date:** ____________________

Printed Name: ____

Manual Solutions Gymnasium Release, Waiver, and Hold Harmless Agreement

Participant

Name:________________________________

Address:______________________________

____

Phone:_______________________________

Email:_______________________________

(As used herein, Participant includes the above identified individual and the parents/guardians of the Participant.)

Participant requests permission from Manual Solutions PLLC (Manual Solutions) to use its gymnasium, gym facilities, and gym equipment (collectively "the gym").

In consideration for the use of the Gym by Participant, Participant acknowledges, agrees and represents as follows:

Health Disclaimer

Participant is in good health or has otherwise been cleared by a healthcare professional to participate in specified gym activities. Participant accepts full responsibility for Participants medical conditions, if any, as they relate to engaging in exercise and using the Gym. Participant has consulted with a physician, has been cleared by Participant's physician to engage in exercise. Participant will refrain from engaging in exercise or using the Gym in a manner which exceeds Participants medical clearance or which poses a health risk to Participant or other users as a consequence of Participant's disability, impairment, medical condition, illness or health related issues.

Assumption of Risk

Patient acknowledges that Patient's presence in and use of the Gym involves risk. Patient knowingly and freely assumes all risk and responsibility for any and all bodily and/or personal injury, including death, and damage to property that may occur in connection with Patients use of the Gym.

Release/Covenant to Not Sue

Participant forever releases, discharges and covenants to not sue (and relinquishes any and all rights to sue) Manual Solutions, its managers, officers, shareholders, agents, employees, attorneys, and their respective successors and/or assigns (each and "MS Agent") from and with respect to any and all liability, claims, demands, actions, suits, rights, and/or causes of action of whatever kind or nature, now or hereafter existing, whether known or unknown, present or future, foreseen or unforeseen, whether caused by the negligence of Manual Solutions or a MS agent or otherwise, that may arise from Participant's use of the Gym, including, without limitation, any bodily and/or personal injury, including death, and damage to property. Participant waives any protections afforded by any statute or law in any jurisdiction whose purpose, substance, and/or effect is to provide that a general release shall not extend to claims, material or otherwise, which person giving the release does not know or suspect to exist at the time of executing the release. This means, in part, that Participant is releasing any and all unknown future claims.

Indemnification/Hold Harmless

Participant will indemnify and hold harmless Manual Solutions and any MS Agent from and against any loss, damage, claim, suit, liability, demand, cost and/or expense, paid or incurred by Manual Solutions or any MS Agent, or asserted against any of them (including attorney's fees, court costs and disbursements) caused in whole or in part, by, or arising directly or indirectly out of Participant's breach of this Gym Release and Waiver.

Responsibility for Personal Property

Manual Solutions has advised me not to bring valuable personal property into the Gym. I assume full responsibility for any loss of or damage to my personal property which may occur at the Gym. Manual Solutions shall not be liable for the loss, theft, or damage of any personal property located anywhere in the Gym.

No Supervision

I have been informed and acknowledge that Manual Solutions will not provide any trainers or other supervision at or in connection with the Gym. I agree to use the Gym without any such supervision at my own risk.

No Warranty

I have neither requested nor received any express representations or warranties as to the use of the Gym and Manual Solutions has not made and does not make any actual or implied representations or warranties regarding the condition or appropriate use of the Gym.

Non-Transferable/Non-Assignable

This gym Release and Waiver has been executed by me and may not be used by any other person for the purpose of using the Gym.

Acknowledgment of Gym Rules

I have received a copy of the Gym rules and regulations and agree to abide by them and any amendments to them hereafter adopted. I agree that Manual Solutions may suspend or revoke my right to use the Gym upon determining, in its sole discretion, that I have materially violated the Gym rules and regulations or that I have materially breached the terms of this Gym release and Waiver.

Acknowledgement of Accountability

Manual Solutions may repair, at my expense, all damage to the Gym caused by me, and I agree to pay Manual Solutions on demand any amounts so expended.

Dispute Resolution

Any dispute or question concerning the use of the Gym shall be resolved by the Directors of Manual Solutions and the decision of the Directors of Manual Solutions shall be binding upon me in all respects.

No Limitations

This Gym Release and Waiver covers any and all liability, claims and actions caused entirely, or in part, by any and all acts or failures to act on my part, including but not limited to, negligence or mistake.

This Gym Release and Waiver shall also bind my assigns, heirs, executors, administrators, distributees, guardians and next of kin.

Choice of Law

This Gym Release and Waiver shall be governed by, constructed and enforced in accordance with, the laws of the State of Idaho, without giving effect to conflict of law principles.

Severability

If any term or provision of this Gym Release and Waiver is held to be illegal, invalid or unenforceable, or the application thereof to any person or circumstance shall to any extent be illegal, invalid or unenforceable under present or future laws, then and in such event, it is the express intention of the parties that the remainder of the Gym Release and Waiver, or the application of such terms, clauses or provision other than to those as to which it is held illegal, invalid or unenforceable, shall not be affected thereby, and each term, clause or provision of this Gym Release and Waiver, and the application thereof, shall be legal, valid and enforceable to the fullest extent permitted by law.

Entire Agreement

This Gym Release and Waiver constitutes the entire agreement of the parties with respect to the subject matter of thys Gym Release and Waiver and supersedes all prior agreements, understandings, negotiations, statements, promises and discussions, oral and written, between the parties hereto with respect to the subject matter of this Gym Release and Waiver.

Survivability

The Provisions of this Gym Release and Waiver will continue in full force and effect even after the termination of the activities conducted by me at the Gym.

Acknowledgment of Receipt and Execution

I have read and fully understand the terms of this Gym Release and Waiver, and that I may HAve given up substantial rights by signing it, and sign it freely and voluntarily without any inducement. I agree to abide by and be bound by the terms and conditions of this Gym Release and Waiver. I have had an opportunity to consult counsel regarding this Gym Release and Waiver.

Signed:______________________________

Printed Name:________________________

Dated this ___ day of ____________, 20___.

For Participants of Minority Age (under 18)
If the above-signed is under eighteen (18) years of age (a "Minor") then Manual Solutions must first consent in writing to the Minor's use of the Gym. Provided Manual Solutions consents in writing to the Minor's use of the Gym, a parent of such Minor must accompany and supervise the Minor at all times during such Minor's use of the Gym, and the parents of the Minor must execute this Gym Release and Waiver below, agreeing to be bound by, for and on behalf of the Minor, all terms and conditions contained herein.

This is to certify that I, as parent with legal responsibility for this Minor, do consent and agree to such Minor's execution of this Gym Release and Waiver, and I, for myself and on behalf of such Minor, agree to be bound by all terms and conditions contained herein.

Dated this ______ day of ____________, 20___

Signed: ________________________________
Printed Name: __________________________

Self-Assessment

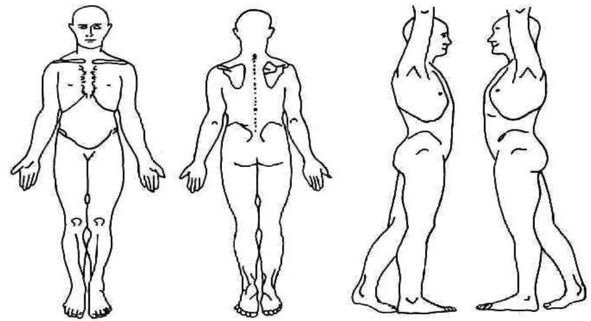
Patient Name: **Today's Date:**

Body part being Treated today: **Date of Follow up with primary physician:**

1. On the diagram, shade in the areas where you feel pain.

   A) Put an x on the area that hurts most

   B) Label areas of numbness or tingling



2. Please describe the pain and explain what you believe the cause to be?____________________________
____

3. What kind of things/activities make your pain worse (walking, standing, lifting, ect)? __________________
____

4. What kinds of things/activities make your pain better (heat, ice, medicine, rest, ect)? _________________
____

5. Have you had surgeries in the past? _______ Yes _______ No
   If yes, please list each surgery date and type? ____

6. Have you had recent X-Rays, MRI, or labs? _______ Yes _______ No
   If yes, what were the results? ____

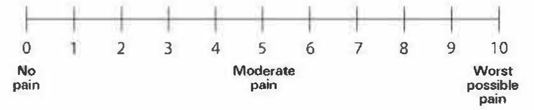
7. Have you ever received physical therapy for this problem? _______ Yes _______ No
   If yes, by whom? ___________________________ What did you have done? __________________________

8. How long has it been since you first learned your diagnosis? ___________ Months________

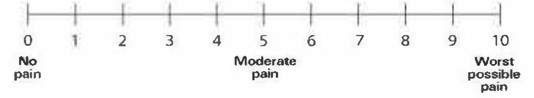
9. Do you believe pain is coming from a medical condition unrelated to your primary diagnosis (arthritis, bursitis, degeneration, ect)? ____ Yes ___ No

10. Is another party, insurance other than your current personal insurance responsible for payment of your injury claims? _______ Yes _______ No

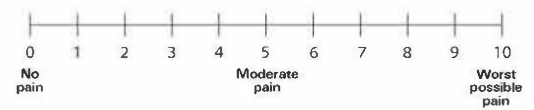
11. Please rate your pain by circling one number that best describes your pain **RIGHT NOW.**



12. Please rate your pain by circling one number that best describes your pain at its **LEAST** in the past 24 hours.

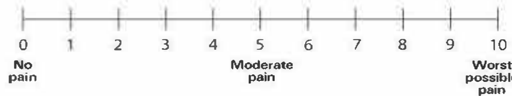


13. Please rate your pain by circling one number that best describes your pain at its **WORST** in the past 24 hours.

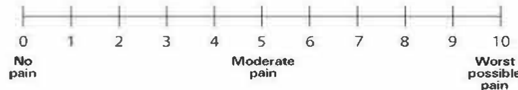


14. Circle the number that describes how, during the past 24 hours **PAIN HAS INTERFERED** with your:

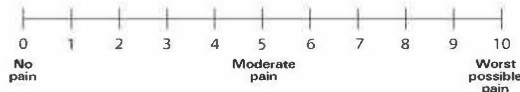
A. General Activity:



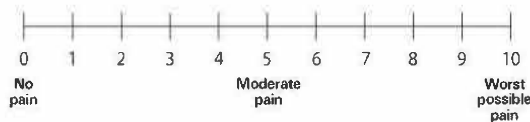
B. Sleep:



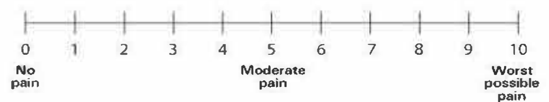
C. Walking Ability:



D. Lifting Ability:

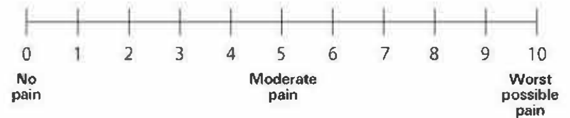


E. Standing Ability:



F. Sitting Ability:

G. Normal Work:



15. What treatments are you currently receiving for your condition? ____

____

16. Do you have a history of Osteoporosis? _______ Yes _______ No

17. Have you experienced 1 or more fall(s) in the last 12 months? __ Yes _______ No

If yes:

a. How many? __________

b. Where did the falls(s) occur? Indoor Outdoor

c. What caused the fall(s)? ____

____

d. Did you experience any feeling of dizziness before or after the fall? _______ Yes _______ No

e. Did you experience a “blackout” sensation? _______ Yes _______ No

18. **List all Medicine you are currently taking:** Prescription and over-the-counter medication (examples: aspirin, antacids) and dietary supplements (example: vitamins) and herbals (examples: ginseng, gingko). Include medications taken as needed (examples: inhalers, nitroglycerin).

Prescription Medication Name	Dose (how much)	Frequency (how often)

Over the Counter Medications/Vitamins/Herbals

Name of Medication	Dose (how much)	Frequency (how often)

Please attach additional pages if more room is necessary