MEDICAL INTAKE FORM

PATIENT INFORMATION

LAST NAME	FIRST NAME	DATE OF BIRTH	SSN#

STREET ADDRESS	CITY	STATE & ZIP CODE

HOME PHONE	CELL PHONE	WORK PHONE
LEAVE MESSAGE? YES NO	LEAVE MESSAGE? YES NO	LEAVE MESSAGE? YES NO

EMAIL ADDRESS:	HAVE YOU HAD PHYSICAL THERAPY IN THE LAST 12 MONTHS? YES NO
APPOINTMENT REMINDERS: ☐ Email ☐ Text	IF YES TO OUTPATIENT PT, HOW MANY VISITS THIS YEAR?

NAME OF EMERGENCY CONTACT	ADDRESS OF EMERGENCY CONTACT	RELATIONSHIP	CELL PHONE

DATE OF MOST RECENT SURGERY	WHO REFERRED YOU TO US	PRIMARY CARE PHYSICIAN

PLEASE CHECK OR ADD ANY TESTING YOU HAVE RECEIVED

BLADDER SCAN	COLONOSCOPY	DEFOGRAM	CT SCAN	CYSTOSCOPY	MRI
NERVE CONDUCTION	URINE TEST	URODYNAMICS	PET SCAN	X-RAY	OTHER

PLEASE CHECK OR CIRCLE ALL THAT APPLY TO YOU

ALLERGIES	CANCER	CONGESTIVE HEART FAILURE	CONSTIPATION
ENDOMETRIOSIS	DEEP VEIN THROMBOSIS	FIBROMYALGIA	HEART DISEASE
HIGH CHOLESTEROL	HYPERTENSION	IRRITABLE BOWEL SYNDROME	INTERSTITIAL CYSTITIS
KIDNEY DISEASE	OSTEOPOROSIS	OSTEOPENIA	RECENT/ACTIVE INFECTION
THYROID DISEASE	TRAUMA/SEXUAL ABUSE	WEIGHT OR ENERGY LOSS	OTHER:

Current Height_____ Current Weight_____

Please write more details if you checked or circled any of the above boxes:

_____

_____

_____

Please list any hospitalizations other than surgery:

_____

_____

_____

Updated 12/10/2019

MEDICAL INTAKE FORM

Do you take any medications including over the counter or herbal medications? YES NO
If yes, please write below and include prescriptions, over the counter, herbals, and vitamin/mineral supplements.

Medication/Vitamin	Date:		Date:		Date:	
	Dosage	Frequency	Dosage	Frequency	Dosage	Frequency

Please List Surgeries

Date	Surgery

Patient Signature Date

By signing this form, I certify that all of the above information is accurate in its entirety.

Updated 12/10/2019

STATEMENT OF PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED &HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We may disclose your health care information 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 procession.

We may disclose your health information to a law enforcement official 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.

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 in certain legal circumstances we might be unable to honor the restriction that you requested.

Updated 12/10/2019

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 at 720-402-3801. 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 this notice.

By way of my signature, I provide Nishimoto and Neujahr Physical Therapy with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the privacy notice.

Patient Name

Patient Signature

Date

Financial Policy for Nishimoto and Neujahr Physical Therapy, LLC

Financial Policy:
For all medical services provided by N2 Physical Therapy, payment is due at the time of service. For our patients with medical insurance coverage, co-pays and deductibles which have not been satisfied will be due at the time of service. For patients not submitting claims to insurance, we offer a flat rate of $105.00 per visit.

Insurance: N2PT will contact your insurance company to obtain a verification of your physical therapy benefits prior to initiating therapy. N2PT will only file the claim amount to the patient's primary and secondary insurance. After your insurance has processed the claim, all remaining amounts after contractual adjustments will be patient responsibility. If your insurance fails to respond to a properly filed claim in 60 days, any remaining amounts will be patient responsibility and due in full.

We strongly recommend that you personally verify your own physical therapy coverage within your policy. Please call the customer service number on your insurance card. The information required includes:

- What your co-pay, deductible and/or co-insurance is for physical therapy services.
- Number of physical therapy visits available to you per calendar year, and how many have been used.

It is not guaranteed that insurance companies will pay for all services rendered and/or authorized, and the amounts they verify are not guaranteed by them to be accurate. Should your insurance not pay for services provided by N2PT, the costs associated with your physical therapy visits will be your responsibility. N2PT reserves the right to take whatever legal or other action that is necessary to bring your account current, including but not limited to outside collection proceedings and/or termination from our practice. All accounts over 90 days will be turned over to collections. Payments will be applied with intention to keep your account as current as possible to avoid collections, versus always to the date the payment was made.

Visit Limitations: There may be a cap on the number of physical therapy visits that your policy allows per year. **N2PT is not responsible for keeping count of your allowed visits per year**. Please keep track of the number of visits that you use with us, and at other outpatient facilities, as they will also count towards your total yearly count of visits. **Visits that exceed the allowed visits per year will be charged the $105.00 self-pay rate.**

In consideration of treatment by the therapist(s) at N2 Physical Therapy, I the undersigned-(s), jointly and severally, understand the terms and conditions above and without limitation agree to the following:

1. I am responsible for all fees relative to the professional services rendered under this agreement, that this may include me, my family, or other individuals that I authorize, and that this agreement as it relates to my financial responsibility extends to all past, present, and future services rendered by N2 Physical Therapy to me, my family, or other individuals I may have authorized. I recognize that insurance is a contract between the patient and the insurance company, and I agree that I will pay all charges under this agreement regardless of my insurance coverage. I may terminate my responsibility under this agreement by paying my account in full and giving written notice to N2 Physical Therapy.
2. I will pay all sums that are due and payable at the time of service. No oral agreements have been made and this agreement cannot be modified orally.
3. In the event that I direct medical claims to any insurance company other than my current general medical insurance provider including but not limited to worker's compensation and auto insurance;
    a. I further agree to be bound by the financial Policy Addendum, attached hereto; and
    b. I shall direct payments from insurance to be made directly and solely to N2 and shall not allow any third party to retain sums owed to N2 Physical Therapy.
4. I, the patient authorize payment for services made directly to N2 PT, which may otherwise be payable to me from all sources including medical insurance, worker's compensation or other parties for medical benefits with whom I have contracted. Such benefits will not exceed N2PT's billed charges. I hereby accept full responsibility for providing N2 PT accurate and complete information needed for their assisting me in processing my claims for reimbursement. I authorize the refund of overpaid Insurance benefits where my coverage is subject to coordination of benefits.
5. I will be charged a $10 finance fee for each successive 30-day statement billed to collect my balance after my initial statement is sent. At 90 days in accounts receivables, I understand I will be notified once by email and then an 18% finance charge will be added to my balance, and it will be sent to collections. Once my account is in collections I understand I will no longer be able to pay directly through N2 Physical Therapy.

Collections Policy:
If you do not pay your bill within 30 days, you will be issued an email notice and second statement. At the 90-day period unpaid we will forward your account to collections and settlement will occur with them. Please indicate here and tell the front desk if you prefer a phone call: _____. If left blank email will be the primary means of communication.

Patient Printed Name_____ Date_____

Patient Signature_____

Updated 12/10/2019

Patient Authorization

	Authorization for Treatment ➢ I hereby give authorization for the performance of such rehabilitation procedures as permitted by Colorado Statutes under the appropriate scope of practice are, in the judgment of my Therapist, deemed necessary.
	Authorization for Release of Information ➢ I agree that Nishimoto and Neujahr Physical Therapy may provide information from my medical record to persons involved in my medical care. ➢ I authorize the release of medical information necessary to obtain payment of any benefits available to me to Nishimoto and Neujahr Physical Therapy services rendered. ➢ I agree that Nishimoto and Neujahr Physical Therapy may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. ➢ I have read "Notice of Privacy Practices" mandated by HIPAA.
	Authorization for Release of Payment ➢ I authorize that direct payment of any benefits available to me be released to Nishimoto and Neujahr Physical Therapy for services rendered.
	Patient Agreement ➢ I agree to pay Nishimoto and Neujahr Physical Therapy charges for services rendered to me during my course of treatment. ➢ I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay Nishimoto and Neujahr Physical Therapy collections costs including attorney and court fees.
	Medicare, Medicaid, and Similar Benefits ➢ I agree that the information given to Nishimoto and Neujahr Physical Therapy in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that Nishimoto and Neujahr Physical Therapy may give Social Security Administration or its fiscal intermediary's information necessary to process claims.
	Workers Compensation ➢ I agree that the information given to Nishimoto and Neujahr Physical Therapy in applying for benefits under Workers Compensation is complete and accurate. I agree that Nishimoto and Neujahr Physical Therapy may give intermediary's information necessary to process claims.

By signing this form, I agree to all of the above in its entirety.

_____ _____

Printed patient name Date

_____

Patient signature

Updated 02/07/2020

Attendance Policy

We are pleased that you have chosen N2PT for your physical therapy. To provide the best possible outcome for you, compliance and attendance are of the utmost importance. Please read the following policies, effective March 1st, 2020 carefully, and sign and acknowledge at the bottom of this form.

No Show and Late Cancellation:
Any appointments not canceled via phone call or phone message within 24 hours are considered a no show or late cancellation. After your first violation you will receive a notice letter, and each violation thereafter will be assigned a fee of $60 and documented. ***Emails to your physical therapist or in response to your reminder are not acceptable means of cancellation. Cancellations via responding to your reminder via text or email are not acceptable means of cancellation.*** After three no show and/or late cancel violations, your physical therapist reserves the right to discontinue your care.

Late Arrival:
Receiving your entire appointment is mandatory to your plan of care. Check in time for an initial evaluation appointment is 15 minutes prior to your scheduled time, and for follow up visits we ask that you check in 5 minutes prior to your scheduled time. Arriving more than 15 minutes late after your scheduled time will result in a warning and discussion with your physical therapist. Any subsequent late arrival will be charged a fee of $15.00 per occurrence in addition to your copay or coinsurance and not covered by insurance. Patients who self pay will be required to pay for the entire visit at the rate of $105. Please allow enough time for street, garage, or valet parking at our city and hospital locations.

Appointment Reminders:
Text or email communication appointment reminders are set up as a courtesy to our patients. It is ultimately your responsibility as a patient to keep track of your appointment dates and times. Late cancellations and/or no shows because your system, or our system, failed to connect are not acceptable or waived for this reason.

I, _____, (printed name) have read and understand the above policies and understand that these fees are not payable by insurance. I understand I will be responsible and required to pay for for no show and late cancellation fees.

Patient Signature_____. Date of Signature_____

Administrator Signature_____. Date of Signature_____