Physical Therapy

Patient Financial Agreement

Patient Copy

Cancellation Policy

If the patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to **cancel before 24 hours** of the appointment time. A fee of **$75.00 will be charged for the first appointment** that is cancelled with less than 24 hours' notice, and **$150.00 for each subsequent appointment**. In the event of any illness/emergency we require you contact our office before 8am the day of your appointment. If you are scheduled for an appointment on Monday, we ask that you cancel by the previous Friday before 12:00 pm. If for any reason our staff is unavailable to receive your call you may leave a detailed message on our voicemail system.

Late Policy

Our office is one of the few physical therapy practices that allows 50-55 min treatments for each of our patients one-on-one with a therapist. Because our practice is a specialty practice, we schedule appointments for 50-55 minutes each visit. That time is dedicated just for you. We do not see any additional patients during that time like traditional Physical Therapy. Because we offer one on one treatments for that 50-55 minute, your insurance carrier will only pay for time that you are in our office receiving treatment or being assessed. Therefore, any time you miss for that treatment will be your responsibility. Insurance does not cover late or missed appointment fees. Insurance is billed in increments of 15 minutes therefore any missed treatment time for 8-15 minutes will cost you approximately $25.00 per 15 minutes (depending on your insurance carrier). This does not include your copay or coinsurance.

We want every patient to receive as much treatment as possible each visit. So, it is very important to arrive for your appointment on time and be prepared to stay for approximately 50-55 minutes. If you have any questions or concerns, please feel free to speak with one of our office staff. Thank you for allowing us to participate in your healthcare program. It is an honor and a pleasure to have you at our practice.

Early Leave Policy

If the patient cannot stay for the 50-55-minute appointment time, he/she will be responsible for any unbillable time. Please inform the front office if you will not be able to attend the full appointment time.

Authorization/ Assignment/ Financial Responsibility

I authorize the release of any medical information necessary to process an insurance claim(s) on my behalf. I understand that I am financially responsible for all charges and that I am responsible for obtaining any referrals required by my insurance carrier. I request that my medical insurance/ automobile insurance carrier make payment directly to Hands On physical Therapy for services rendered to me. As a courtesy, my charges will be filed with my insurance carrier; however, I will be billed if the claims are denied or are not paid in a timely manner. Should my account become a collection problem, additional charges may be incurred.

→ I, _____, have read a copy of the privacy practices. (This document is available at our front desk).

→ _____(Initial) **Cancellation Policy**

If the patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel before **24 hours** of the appointment time. A fee of **$75.00** will be charged for the first appointment that is cancelled with less than 24 hours' notice, and **$150.00** for each subsequent appointment. In the event of any illness/emergency we require you contact our office before **8am** the day of your appointment. If you are scheduled for an appointment on Monday, we ask that you cancel by the previous Friday before 12:00pm. If for any reason our staff is unavailable to receive your call you may leave a detailed message on our voicemail system.

→ _____(Initial) **Late Policy/Early Leave Policy**

Our office is one of the few physical therapy practices that allows 50–55-minute treatments for each of our patients one-on-one with a therapist. Because our practice is a specialty practice, we schedule appointments for 50-55 minutes each visit. That time is dedicated just for you. We do not see any additional patients during that time like traditional Physical Therapy. Because we offer one on one treatments for that full time, your insurance carrier will only pay for time that you are in our office receiving treatment or being assessed. Therefore, any time you miss for that treatment time will be your responsibility. Insurance does not cover late or missed appointment fees. Insurance is billed in increments of 15 minutes therefore any missed treatment time for 8-15 minutes will cost you approximately $25.00 per 15 minutes (depending on your insurance carrier). This does not include your copay or coinsurance.

We want every patient to receive as much treatment as possible each visit. So, it is very important to arrive for your appointment on time and be prepared to stay for approximately 50-55 minutes. If you have any questions or concerns, please feel free to speak with one of our office staff. Thank you for allowing us to participate in your healthcare program. It is an honor and a pleasure to have you at our practice.

→ _____(Initial) **RELEASE OF MEDICAL INFORMATION**

→ **I DO / I DO NOT (**circle one) authorize Hands On Physical Therapy to release medical information to my spouse, parent or guardian.

→ _____(Initial) **Contact Permission**

In the event that Hands On Physical Therapy needs to contact you (patient) regarding appointments, billing, treatment or any other reason, it is permissible to:

☐ Leave a message on the answering machine. Phone# you wish us to call_____

☐ Speak with a spouse/significant other.

☐ Speak with other family members.

→ _____(Initial) **Consent to Treatment**

I consent to the performance of examinations and rendering of treatment by the medical provider and their designated medical office staff as is deemed necessary in the medical provider's judgment.

→ _____(Initial) **Authorization/ Assignment/ Financial Responsibility**

I authorize the release of any medical information necessary to process an insurance claims on my behalf. I understand that I am financially responsible for all charges and that I am responsible for obtaining any referrals required by my insurance carrier. I request that my medical insurance/ automobile insurance carrier make payment directly to Hands On Physical Therapy for services rendered to me. As a courtesy, my charges will be filed with my insurance carrier; however, I will be billed if the claims are denied or are not paid in a timely manner. Should my account become a collection problem, additional charges may be incurred.

→ **My signature below indicates that I have read and am in agreement with all statements that I have initialed above.**

_____ _____

Signature of Patient (or Guardian) Date

Physical Therapy

Patient Information

Myofascial Release, Pain Relief, Headaches,
Neck/ Back Pain, Women's Health

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT INFORMATION

NAME (LAST. FIRST. MI) _____

ADDRESS _____

CITY _____ ST_____ ZIP _____

HOME# _____ CELL#_____ WORK#_____

EMAIL (TO RECEIVE UPDATED EVENTS ANT) NEWS) _____

DOB_____ SS#_____MARITAL STAT S M W D

PHYSICIAN NAME _____ADDRESS/ PHONE#_____

EMERG CONTACT _____ PH#_____ RELATIONSHIP _____

EMPLOYER INFORMATION (OF INSURED PERSON)

EMPLOYER _____ PHONE#_____

ADDRESS _____ CITY_____ ST_____ ZIP_____

INSURANCE INFORMATION

TO ASSURE PROPER FILING OF YOUR CLAIMS, PLEASE PROVIDE YOUR CARD SO THAT WE MAY COPY IT FOR OUR RECORDS

INSUREDS NAME_____ DOB _____ SS# _____

INSURANCE CO _____ PHONE # _____

INSURANCE ADDRESS_____

GROUP#_____ ID#_____ RELATION _____

301 Hester's Crossing. Suite #160 Round Rock. TX 78681 Ph: (512) 310-1928 Fax: (512) 310-9180

HANDS ON
Physical Therapy & Advanced Massage Therapy

Name: Height: Weight: Date:

1. Current Complaint (s): (list in order of most severe to least severe): _____
   _____
   _____

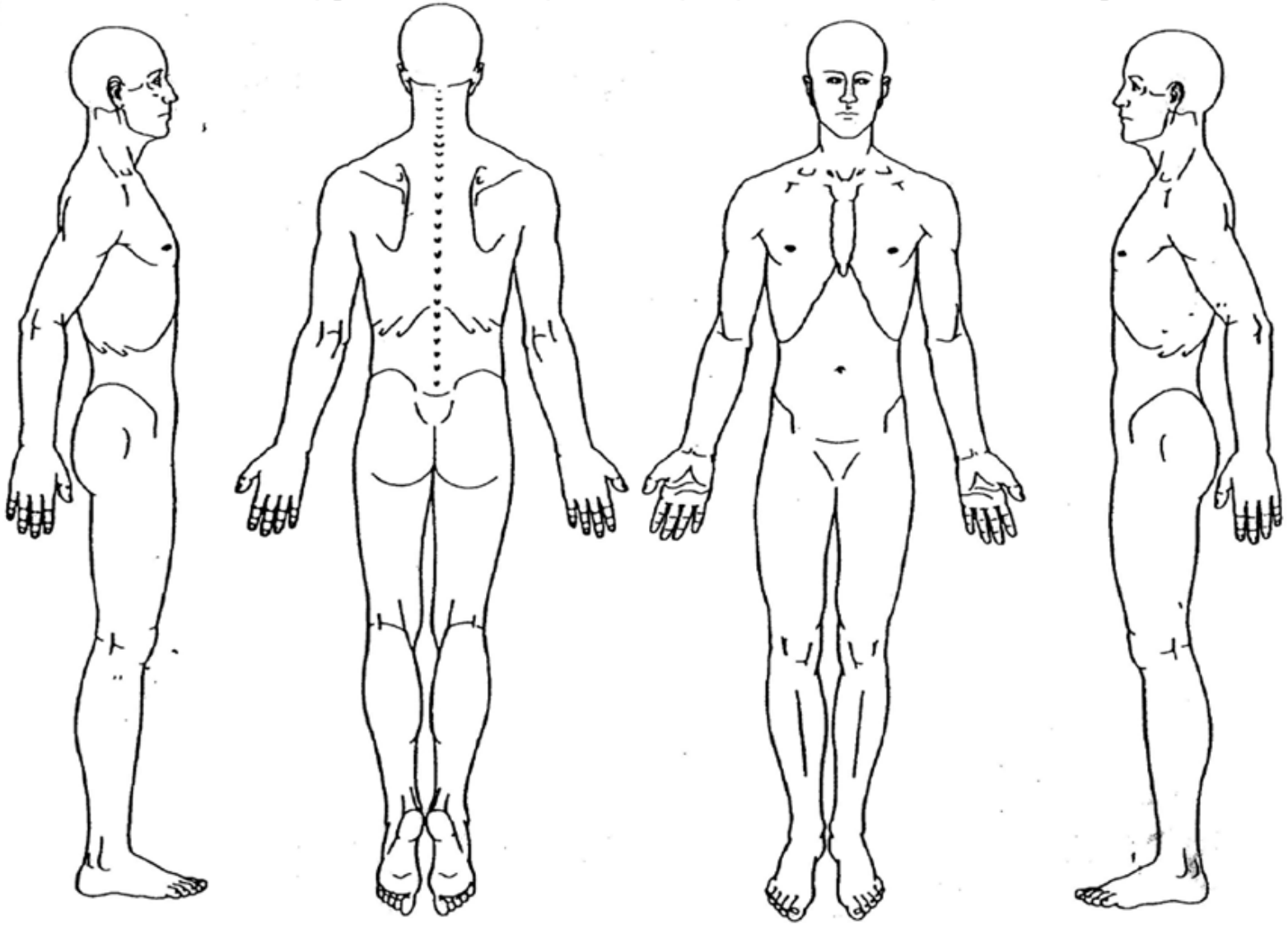
2. Is this injury related to a work injury or motor vehicle accident? If so, how did this injury occur and when? Are you currently working with an attorney or insurance carrier for a settlement or payment of claims? _____
   _____

3. Medical history: (Please include dates if known)
   ☐ Diabetes 1 or 2 ☐ High Blood Pressure ☐ Allergies
   ☐ Cancer ☐ Pregnancies
4. Other Conditions/ Illness: _____
5. Past Injuries/Surgeries include dates if available: _____
   _____
6. Current Diagnostic studies ☐ X-Ray ☐ MRI ☐ CT scan
7. Current Medications: Please list any prescriptions, OTC, Herbal, Vit & Min, Dietary Supplements

Name	Dose	Frequency	Oral	Purpose of taking

8. What is your goal for Physical Therapy?
   _____

Please circle any pain areas, even if you feel they may be unrelated to your chief complaint.



BODY DIAGRAM