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Xtreme PHYSICAL THERAPY

3300 Behrman Pl, New Orleans, LA 70114, Office 504-374-0015 Fax 504-374-0016 ~ 5555 Bullard Ave Su 102 * New Orleans, LA, 70128 Office 504-245-2483 Fax 504-245-2489

Welcome

We are glad that that you have chosen Xtreme Physical Therapy for your rehabilitation needs. We are committed to providing you with the best possible care and in order to insure that your time with us will be a satisfactory experience, the following information concerning the management of this practice is offered.

Appointments

Services are provided by appointment only; please make your appointment when you leave. If you are unable to keep your appointment, or run late, we ask that you please notify us as soon as possible so that the appointment will be available for someone else. If proper notice is not received, your referral source and insurance company will be notified of each missed appointment. We may assess a fee for repeated missed appointments which are not cancelled in a timely manner. Appointments are available Monday thru Friday 7:00 a.m. – 7:00 p.m. and Saturday 8:00 a.m. – 12:00 p.m.

Financial Policy

If you have health insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy. We must emphasize that as a Physical Therapy provider, our relationship is with the patient, not the insurance company. While filing insurance is a courtesy we extend to all of our patients, all charges are your responsibility. As soon as information is presented, we will contact your insurance company for verification of coverage and benefits. **IMPORTANT** – To ensure accuracy and full benefits, verify with your insurance booklet the benefits you have regarding physical therapy. Each policy may have different guidelines. Some insurance companies require a referral number or pre-certification prior to the start of treatment.

If you are required to pay any co-pays or co-insurance, all fees are due at the time that services are rendered. It is important to understand that insurance claims may take up to 45 days to process. Any remaining balances will be your responsibility. If any payments are made directly to you, they are to be forwarded to XPT. You should notify XPT if any changes have been made to your insurance so that proper actions can take place. There is a $20.00 service charge on all returned checks. Should your account be placed in collections or other legal actions necessary to collect on an overdue account, the patient or patient's responsible party, understands that they are responsible for all costs of collection including, but not limited to, all court costs and attorney fees, and a collection fee up to 50% will be added to the outstanding balance. If hardships should occur, please notify our business office and we will assist you if possible.

I certify that I have read the above information, and that I will notify Xtreme Physical Therapy of any changes to my insurance information provided.

_____ _____

Signature (Parent if patient is minor) Date

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Name: _____ Date of Birth: _____- _____ - _____

Address: _____ City: _____ State: _____

Zip: _____ Phone: _____- _____ - _____ Cell: _____- _____ - _____ Age: _____

Social Security #: _____- _____ - _____ Marital Status: ____ M ____ S ____ Other

Employer: _____ Employer Phone: _____- _____ - _____

Primary Insurance: _____ Policy/I.D. #: _____

Secondary Insurance: _____ Policy/I.D. #: _____

Workman's Comp: _____ Claim #: _____

Adjustor: _____

Date of Injury: _____- _____ - _____ Adjustor Phone: _____- _____ - _____ Ext: _____

Attorney: _____ Attorney Phone: _____- _____ - _____

Attorney Address: _____

Have you received physical therapy this year? ____ Yes ____ No

Are you currently receiving any type of home health services? ____ Yes ____ No

Who is the Doctor that referred you to Xtreme Physical Therapy? _____

How did you hear about us? _____

Is your injury related to: _____ Auto _____ Work _____ Other

Emergency Contact: _____ Phone: _____- _____ - _____

I certify that the information above is true and correct to the best of my knowledge and I will notify Xtreme Physical Therapy of any changes to the above information.

_____ _____

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Name: _____ Date of Birth: _____- _____ - _____

Condition related to: ☐ Employment ☐ Auto Accident ☐ Other

Date condition/injury began _____- _____ - _____ Date of Surgery: _____- _____ - _____

Please list any medication you are currently taking.

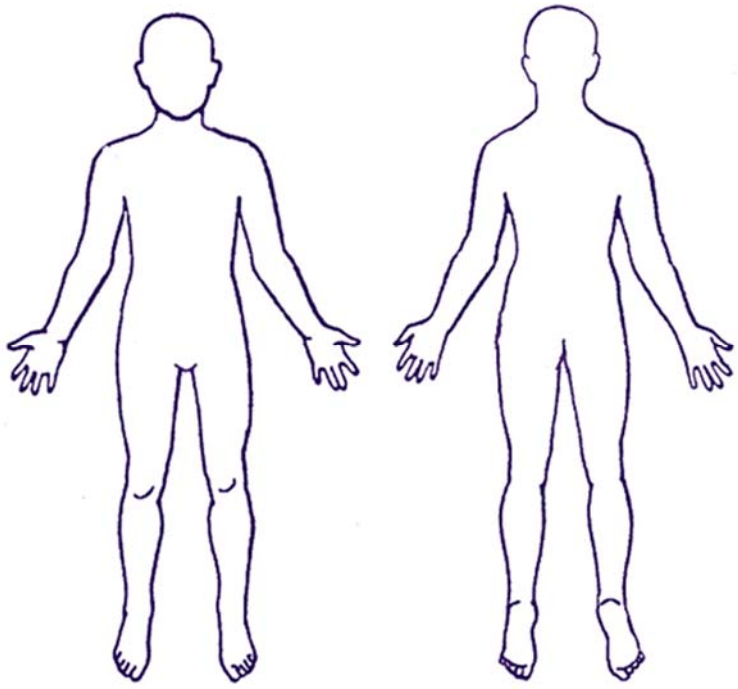
Medication	Milligrams
_____	_____
_____	_____
_____	_____
_____	_____

Pain Scale

Please Rate from 1-10

1 2 3 4 5 6 7 8 9 10

Mild Moderate Extreme



Which of these words describes your pain?

(Check all that apply)

☐ Sharp ☐ Dull ☐ Burning

☐ Aching ☐ Tingling ☐ Numb

☐ Constant ☐ Variable ☐ Radiating

On the model to the left please shade the area of the body where your pain is present.

NotePlease understand that your pain will probably fluctuate as the course of your treatment progresses. If your pain worsens, you may think that treatment is not necessary. Neither of these conditions is s reason not to come. It is imperative that you complete the necessary number of visits prescribed by your doctor.

_____ _____

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Notice of Patient Information Practices

Xtreme Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For Example, XPT may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Xtreme Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing, for research studies, for emergencies and when required by law. Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or patient's responsible party, understands that XPT has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered.

In any other situation, Xtreme Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide written authorization to release information, you may revoke that authorization to stop future disclosures at any time.

XPT may change its policy at any time. When changes are made, the new policy will be available on your next visit. You may also request an updated copy at any time.

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative services. Payment for treatment

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. XPT will consider all such request on a case by case basis, but the practice is not legally required to accept them.

If you are concerned that XPT may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed above. You may also send a written complaint to the US Department of Health and Human Services. For further information on Xtreme Physical Therapy's health information practices or if you have a complaint, please contact the following persons: Tara Smith, Office Manager, (504) 374-0017. Effective Date: 4/2003

_____ _____

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Notice of Patient Information Practices
Xtreme Physical Therapy's LEGAL DUTY

Xtreme Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices described herein. You have the right to receive a copy of our legal duties and privacy practices with respect to protect health information. If you would like a copy please ask. By signing below, I hereby acknowledge I am aware of and have been offered a copy of this notice

_____ _____
Signature (Parent if patient is minor) Date

I also authorize Xtreme Physical Therapy to use my personal health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

_____ _____
Signature (Parent if patient is minor) Date

I authorize Xtreme Physical Therapy to release information to my insurance company and/or Attorney and/or Employer. Where applicable I authorize direct payment of benefits to Xtreme Physical therapy for services rendered.

_____ _____
Signature (Parent if patient is minor) Date

The Patient and/or authorized representative of the patient, whose signature is affixed below, does hereby consent to any and all medical treatments at Xtreme Physical Therapy, LLC which may be deemed advisable by my/the patient's physicians, the intent hereof being to grant authority to administer and perform all therapies which may now or during the course of my/the patient's care be deemed advisable or necessary.

_____ _____
Signature (Parent if patient is minor) Date

If you are unable to keep your appointment, or run late, we ask that you please notify us as soon as possible so that the appointment will be available for someone else. If proper notice is not receive, your referral source and insurance company will be notified of each missed appointment. We may assess a fee for repeated missed appointments which are not cancelled in a timely manner.

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How did you hear about us?

(Please check all that apply)

- ☐ Phone Book
- ☐ Internet
- ☐ Family/Friend
- ☐ Insurance
- ☐ Employee
- ☐ Billboard
- ☐ Church Bulletin
- ☐ Signage
- ☐ Previous Patient
- ☐ Commercial

Doctor: _____

Other: _____

Name: _____ Date: _____

Phone: _____ Email: _____