Fenix Physical Therapy & Performance

Welcome to our practice!
Please help us serve you better by taking a few minutes to provide the following information

Patient Information

Last name	*First name*	*Middle initial*
Address	*City*	*Zip code*
Date of Birth	☐ *Female* ☐ *Male*	*Employer (optional)*
Occupation		

Contact Information

Home Phone	*Cell Phone*	*Work Phone (optional)*
Email		
Emergency Contact Name	*Contact Phone Number*	*Relationship to Patient*

Healthcare Information

Primary Care Physician	*Clinic Name and Phone Number*
Specialist's Name	*Clinic Name and Phone Number*
Specialist's Name	*Clinic Name and Phone Number*

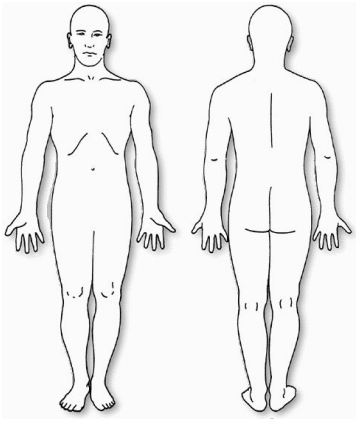
If your referring doctor would like progress notes, please give us their name and clinic information

How did you hear about Fenix Physical Therapy & Performance?

Lifestyle

Do you engage in regular exercise?	YES NO			
What type and how often?				
Are you able to exercise now?	YES NO			
Do you have discomfort, shortness of breath, or pain with exercise?	YES NO			
In general, your lifestyle is:	1 2 3 4 5			
	Active Average Inactive			
Do you smoke?	YES NO	If "yes", how much?		

Your Current Condition

What is the primary issue/problem that brings you in today?	**Please shade in areas where you have pain, discomfort, or tension.**
	
Secondary concern/problem?	
Are you currently experiencing pain as a result of these symptoms? If yes, what is it like? Describe.	
When did your symptom(s) begin?	

Please rate your pain in the last 24-72 hours Using the "0 -10" scale where 0 is no pain and 10 is the worst possible pain. **When is your pain best?** (circle one) Morning/Afternoon/Evening **When is your pain worst?** (circle one) Morning/Afternoon/Evening	At its worst	
	At its best	
	At present	
	While sleeping	

What other types of treatment have you had for this problem?					
☐ Massage	☐ Bodywork	☐ Physical Therapy	☐ Medications/Injections	☐ Chiropractic	☐ Surgery
Other Medical Treatment:					

I walk for		minutes before needing to rest
I stand for		minutes before needing to sit
I sit for		minutes before needing to change positions/get up

Do you have trouble getting up from a chair?	Yes	No
Do you have trouble putting on your shoes and socks?	Yes	No
Do you have difficulty climbing stairs?	Yes	No

Do you have trouble falling asleep?	Yes	No	Do you find it difficult to change positions in bed?	Yes	No
Is your sleep restful?	Yes	No	How many times do you wake in the night?		
Do you find it difficult to lie down?	Yes	No	How long before you fall back to sleep?	Yes	No

Do you have any other goals for physical therapy?

Brief Medical History

Check the box if you have any of the following medical conditions

☐ Arthritis	☐ Malignancy	☐ Diabetes
☐ Heart Disease	☐ Pacemaker	☐ Kidney Disease
☐ Lung Disease	☐ Circulation Problems	☐ Migraine Headaches
☐ Osteoporosis	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Broken Bones	☐ Metal Implants	☐ Epilepsy/Seizure
☐ Heart Murmur	☐ Pregnancy	☐ Liver Disease
☐ Neurological Problems	☐ Stroke	☐ Blood Thinners
☐ Spinal Fusion	☐ Other, explain:	
Is there a chance you are pregnant at this time?	YES	NO

Have you recently noticed any of the following?

☐ Changes in Bowel or Bladder Function	☐ Dizziness/Lightheadedness	☐ Pain at Night
☐ Weight Loss/Gain	☐ Fever/Chills/Sweats	☐ Headaches
☐ Nausea/Vomiting	☐ Shortness of Breath	☐ Weakness/Fatigue
☐ Changes in Appetite	☐ Difficulty Swallowing	☐ Other (explain below)

List all accidents, surgeries, and/or other traumas

List all allergies

Check here if you have attached a list ☐

Do you have any latex allergies?	**YES NO**	Are you sensitive to adhesive bandages?	**YE S NO**

List ALL medications which you are currently taking, the condition for which you are using them and the dose (Include supplements, herbal, and homeopathic remedies)

I hereby agree that the above information is correct to the best of my knowledge and will inform Fenix Physical Therapy & Performance if and when any information changes.

Signature of Patient/Legal Guardian _____ Date _____

Consent to Examination and Treatment

Physical therapy is a patient care service that aims to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis, and intervention through the use of rehabilitative procedures, mobilization, manual therapy, exercises, and more. Physical therapy also aids the patient in achieving their maximum potential within their capabilities and expedites the length of recovery. Physical therapy is provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

Fenix Physical Therapy & Performance, LLC (Fenix PTP) is a hands-on clinic. Some of the hands-on treatment techniques require deep pressure, which may cause bruising, and periods of increased soreness. This can last from 1-72 hours. Symptoms may also change and move to other parts of the body. This is not unusual and is rarely a concern; however, please ask if you have any concerns or questions.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have plans based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in her treatment.

Your response to physical therapy intervention varies from person to person. Therefore, **Fenix Physical Therapy and Performance, LLC, does not guarantee what your response will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition for which you are seeking treatment.** The number of treatments needed and recovery time can vary due to the age of the injury and patient, number of times injured, and many other contributing factors. Furthermore, there is a small possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

Fenix PTP also provides hands-on strength and conditioning services and may involve placing of hands on the client in a professional manner to guide feedback for better movement or instruction on new techniques. All procedures will be explained to the patient prior to performing. There is a small risk that strength and conditioning may cause an increase in symptoms, but they should not last for more than 24 to 48 hours.

By signing below, I do hereby agree and give my consent for Fenix Physical Therapy & Performance, LLC, to furnish care and treatment to me or the minor patient listed below that is considered necessary and proper in diagnosing and treating my physical condition, both physical therapy and/or strength and conditioning. This may include, but is not limited to exercise, hands-on treatment, or use of medical tools and devices, whose purpose will be explained prior to use. I understand that Austin Fair, PT, DPT and Bradley Hall, PT, DPT of Fenix Physical Therapy & Performance, LLC will take into consideration my/minor patient's conditioning and use his or her best judgment for my minor patient's safety to help achieve the goals for the treatment. I understand any potential risks, advantages of treatments, and options I have for alternatives. I agree to fully cooperate with and actively participate in all physical therapy procedures and comply with the established plan of care. I understand that I may start my request for treatment before any procedure or test.

Signature of Patient/Legal Guardian _____ Date _____

Payment Agreement

Thank you for choosing Fenix Physical Therapy & Performance, LLC as your physical therapy provider. Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

- You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.
- Payment is expected at time of service unless we agree to accept assignment from your health plan or other responsible payor and you check the assignment box on the following page or you have made other payment arrangements with us.
- **Out-of-Network Policy.** (Does not apply to Medicare) If we are out-of-network with your health plan and you have out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. You are responsible for contacting your insurance company to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services. On a case-by-case basis, we may, at our sole discretion, agree to accept assignment from your health plan. This means we will bill your health plan for our services directly and await payment from your health plan. If we accept the assignment, you agree that if your health plan does not honor the assignment and sends payment to you, you will promptly forward the payments to us. You further agree that if your health plan denies payment of our claims, in whole or in part, you are responsible for paying any and all unpaid amounts within thirty (30) days of receiving our statement.
- **Medicare Policy.** Fenix Physical Therapy & Performance, LLC is enrolled as a Medicare Provider for our offices at Trilogy at Power Ranch, and CrossFit HiFi. Medicare will not pay for rendered services at locations that are not authorized office locations, such as gyms or parks, even if medically necessary. At times you may choose to receive treatment and not use your benefits from Medicare. By choosing to receive our services at a non-authorized location, or at an authorized location and not use your benefit. By choosing to receive our services after being fully informed of these facts, you are exercising your privacy rights under the Health Insurance Portability and Accountability Act (HIPAA) and restricting disclosure of your records and claims to Medicare. This means we will not submit any claims to Medicare on your behalf or provide you with a receipt or bill that you can submit to Medicare yourself and neither Medicare (including Medicare Advantage Plans) nor your Medicare Supplemental Plan will reimburse you for our services even if your services would have been covered if provided by another Medicare enrolled provider or provided by us at the other location where we provide services that is equipped to bill Medicare. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare or your Medicare Advantage Plan for reimbursement or to obtain a denial for a Medicare supplemental insurance plan.
- **Medicare as a Secondary Payer.** If you have a commercial insurance plan, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. However, since you are agreeing to pay privately for your services, you agree not to forward our bill to Medicare to get reimbursed for your copays, coinsurance or deductible. You understand and agree to carry out whatever procedures are necessary to prevent your commercial insurer from automatically forwarding our bills to Medicare.
- **No-fault, Auto and Other Liability Policy.** If a no-fault, auto or other liability insurance policy will be responsible for paying your claims, we may, at our discretion, wait for payment when your case settles. If we do, you agree to pay the late payment interest fees as stated below. You hereby authorize and direct your attorney, adjustor and/or insurance company involved in your case to pay directly to Fenix Physical Therapy & Performance, LLC all sums due and owing for the services you received plus any late payment interest due from any settlement, judgment or verdict rendered in your case. This means you hereby assign and grant a lien to Fenix Physical Therapy & Performance, LLC in any amount sufficient to pay any outstanding balance owed to Fenix Physical Therapy & Performance, LLC and authorize/require your attorney and/or responsible insurance Payor to recognize and comply with this assignment and lien. You further understand that we are not obligated to discount any portion of our service or interest fees when your case settles regardless of the amount of your settlement, judgment or verdict or whether your settlement, judgment or verdict adequately covers your balance due to us.
- **Appeals Policy.** You understand that you are responsible for filing all appeals of adverse benefit determinations. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.
- **Late Payment Interest.** Unless prohibited by applicable law, interest in the amount of 1.5% per month (18% per year) may be added to your bill for any and all claims that are not paid within thirty (30) days of the invoice or statement date. You agree to be personally responsible for paying such interest unless the responsible Payor is required to pay such interest under federal, state or other applicable laws.
- **Collection Policy.** You understand that we are not required to obtain your written authorization to disclose protected health information to a collection agency or court of law that may be necessary to collect payment for services rendered. Should collection proceedings or other legal action become necessary to collect an overdue account, you will be responsible for paying the collection costs plus court costs and filing fees incurred by the practice.

Assignment of Benefits and Authorized Representative Appointment

Assignment of Benefits. I hereby assign and convey directly to Provider all health plan benefits and/or insurance reimbursement benefits (including MedPay and/or Personal Injury Protection benefits), if any, otherwise payable to me for medical services, treatments, therapies and/or examinations rendered or provided by Provider regardless of its managed care network participation status. I also hereby assign and convey any and all rights under ERISA and any other applicable state and federal laws to pursue payment for Provider's services until Provider's claims are paid in full, including but not limited to legally required notices and procedural reviews concerning my benefits and filing a civil action in federal court. I understand that I will no longer be entitled to said rights. I also understand that I may revoke this assignment at any time by sending written notice to the Provider and my health plan. I hereby authorize Provider to release all medical information necessary to process my claims to the responsible Payor. I agree that if any payments are sent to me despite my assignment of benefits to Provider, I will promptly forward the funds and explanation of benefits/payment to Provider.

Fenix Physical Therapy & Performance, LLC accepts **cash, check, or credit card at the time of service** for initial evaluation or follow up visits. Upon completion of the initial evaluation, the therapist will recommend the most appropriate plan of care. All sessions will be one hour in length. The rates are as follows:

Physical Therapy Rates –Wellness

1. **Initial Evaluation/Treatment or Follow-Up Treatment**: $150

Physical Therapy Rates – Mobile Visit

1. **Initial Evaluation/Treatment or Follow-Up Treatment**: $160

We also offer strength and conditioning, golf performance, athlete recovery and sleep hygiene programs: ask your provider for more details

***Patients must prepay for physical therapy and/or strength and conditioning packages to be eligible for package discounts. Treatments are good for up to 12 months.

I HAVE READ, UNDERSTAND AND AGREE TO THESE PAYMENT TERMS.

_____ Date: _____

Signature of Patient and/or Guardian

_____ Date: _____

Signature of Provider Representative

A photocopy of this agreement is to be considered valid, the same as if it was the original.

Consent for Communication

Patients/Clients frequently request that we communicate with them by phone, voicemail, email or text. Fenix Physical Therapy & Performance, LLC respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur. Since email and texting can be inherently insecure as a method of communication, we will only communicate with you by email or text with your written consent at the email address or phone number you provide to us below. Please be aware that if you have an email account through your employer, your employer may have access to your email.

When you consent to communicating with us by email or text you are consenting to email and texting communications that may not be encrypted. As well voicemail or answering machine messages may be intercepted by others. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through phone, voicemail, email or text. Fenix Physical Therapy & Performance, LLC will not be responsible for any privacy or security breaches that may occur through voicemail, email or text communications that you have consented to.

You may choose to limit the type of voicemail, email or text communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text.

I consent to all communication, including but not limited to communication about my medical condition and advice from my health care providers by the following means (check all that you consent to):		
☐ Text	☐ Email	☐ Voicemail
Email address:		
Phone number:		
I **DO NOT** consent to any voicemail, email or texting communication ☐		

Signature of Patient/Legal Guardian

Date

Cancellation and No-Show Policy

When you schedule an appointment with Fenix PTP, you make a commitment to your health. In turn, we guarantee that a time is reserved solely for you. Missed appointments can interfere with your progress in treatment and do not allow the physical therapist and opportunity to offer that time to someone else in need of services. **To ensure that Fenix Physical Therapy & Performance, LLC, best meets the needs of all, it is our policy that patients are responsible for all appointments they have scheduled.**

However, we understand that circumstances arise which cause you to cancel your appointment. It is required that all cancellations occur or at least 24 hours prior to your scheduled appointment time. **If you cancel your appointment less than 24 hours in advance you will be responsible to pay a cancellation fee of $50 for your physical therapy services.** You will be asked to provide a valid credit card and schedule your first appointment and that credit card will remain on your account indefinitely. In addition, it is the responsibility of the client to be on time for their appointment and the entire fee for the scheduled service will be even if the client is late and does not receive the full treatment. This cancellation policy is for all types of appointments. **Extenuating circumstances and special situations will be reviewed on an individual basis for the discretion of Fenix Physical Therapy & Performance, LLC.**

I have read and understand the above written policy statements, please initial here: _____

Newsletter Policy

As a patient of Fenix Physical Therapy & Performance, LLC, you will automatically be signed up to receive our monthly newsletter using the email provided on the "Patient Intake Form". All of your information is kept private and used exclusively for the purposes of keeping you informed of practice news and updates. We promise we will not spam you or flood your inbox with emails. By signing below, I can send to being automatically signed up for the regularly occurring newsletter.

If you **DO NOT** wish to sign up for this newsletter, please initial here: _____

Multimedia Policy

Photographs or videos may be taken during initial evaluation, progress evaluation, follow up visits, and discharge summary. The primary purpose of those photos or videos is for comparison purposes and as educational tools for you. However, video recordings of treatment techniques, and written or video testimonials from our patients help Fenix Physical Therapy & Performance, LLC get the word out about our services to other potential clients by signing below, I grant permission to the right of my image, likeness and sound of my voice as recorded on audio or video without payment or any other consideration and consent to the use of these photographs in a professional manner including for advertising and marketing purposes and print it or on social media.

If you **DO NOT** wish to have any pictures or videos utilize, please initial here: _____

I understand that I retain the right to revoke consent by notifying Fenix Physical Therapy & Performance, LLC in writing at any time. I verify that I have read and understand the above written policy statements.

_____ _____

Signature of Patient/Legal Guardian Date

Out-of-Network (OON) Insurance Benefits Reference Sheet

Navigating insurance can be difficult, we will do everything we can to help you with this process. Below is some helpful information. Please understand, this worksheet was created to assist you in obtaining reimbursement for Physical Therapy services and is not a guarantee by Fenix Physical Therapy & Performance, LLC, of reimbursement to you.

- **Deductible:** A deductible must be satisfied before the insurance company will pay for therapy treatment. Submit all bills to help reach the deductible amount.
- **Co-Pay:** If you have an office visit co-pay the insurance company will subtract that amount from the percentage they will pay. This will affect the amount of reimbursement you will receive.
- **Reimbursement:** The reimbursement percentage will be based on your insurance company's established "reasonable and customary/fair price" for the service codes rendered. This price will not necessarily match the charges billed; some may be less, some may be more.
- **Referral or Prescription:** If your policy requires a referral or prescription from a provider you must obtain one to send in with the claim. Each time you receive an updated referral you'll need to include it with the claim.
- **Pre-Authorization:** If your policy requires pre-authorization and the insurance company doesn't have one listed yet, you'll need to call the referral coordinator at your provider's office. Ask her to file a referral for your physical therapy treatment that is dated to cover your first physical therapy visit. Be aware that referrals and pre-authorizations have an expiration date and some set a visit limit. If you are approaching the expiration date or visit limit you'll need the referral coordinator to submit a request for more treatment.

Steps to Determine OON Therapy Benefits

1. Call the toll-free number for customer service on your insurance card. Select the option that will allow you to speak with a customer service representative, not an automated system. Let the customer service provider know that you are seeing an **out-of-network (OON) or non-preferred provider**.
2. Ask the customer service representative to quote your **OUTPATIENT, OUT-OF-NETWORK** physical therapy benefits. Other terminology for these could be rehabilitation benefits and may include occupational therapy speech, therapy, massage therapy, and sometimes chiropractic care.
3. Ask the questions below to obtain the most information possible to guide your decision.

Questions to ask the Customer Service Representative

1. Do I have a deductible? Yes / No
    a. If yes, how much is it? _____
    b. How much has already been met? _____

2. Do I have a calendar year plan or a benefit year plan?
    a. If a benefit year plan, what are the dates of my coverage?

3. What percentage of reimbursement do I have? (60%, 80%, 90%, are all common) _____

4. Does the rate of reimbursement change because I'm seeing an out-of-network or non-preferred provider?
    a. Yes / No

5. Does my policy require a written prescription from your primary care physician? Yes / No
    a. If yes, will a written prescription from any MD/physician, nurse practitioner (NP) Physician's Assistant (PA), podiatrist, or a specialist your PCP (primary care physician) referred you to be accepted? Yes / No

6. Does my policy require pre-authorization or a referral on file for outpatient physical therapy services?
    a. Yes / No

7. If yes, do they have one on file?
    a. Yes / No

8. Is there a $ or visit limit per year?
    a. Yes / No
    b. If Yes, What is it? _____

9. Do I require a special form to be filled out to submit a claim? Yes / No
    a. How do I obtain it?

10. What is the mailing address you should submit claims/ reimbursement forms to?

_____

11. Is there an online website where I can submit the claim? Yes / No
    a. What is it?