DADEZ PHYSICAL THERAPY, INC.
471 S. ARCH AVE. SUITE 1
NEW RICHMOND WI, 54017
PHONE: (715)-246-3809
FAX: (715)-246-7139

DADEZ

Authorization For Treatment:

I voluntarily consent to physical therapy care encompassing evaluation and treatment procedures. I acknowledge that no guarantees have been made to me about the results of the exam and/or treatment to be provided in this healthcare facility. I authorize Dadez Physical Therapy to provide such treatment.

Initials _____

Medicare Patients Only: (initial only if applicable)
Are you currently, or have in the last 30 days received any type of Home Health Services, physical/ speech/occupational therapy from a home health care agency, transitional care facility or nursing home?

Circle one: **Yes** **No**

If yes, we cannot treat you today unless you have been discharged as Medicare will not pay for our services while you receive any of the above. You are responsible to make us aware of any previous treatment you may have had at an outpatient physical therapy facility in the past 12 months.

Initials:_____

Self Referral: I understand that if I have not been referred by a physician I will be considered a Self-Referral and can be treated for 90 days. After that time, if I would like to continue treatment, I will need to obtain an order from a licensed physician.

Initials:_____

Payment Authorization: I request that payment be made on my behalf to Dadez Physical Therapy for services furnished to me at Dadez Physical Therapy. I authorize Dadez Physical Therapy to release to the Centers for Medicare & Medicaid Services and its agents, and state Medicaid agency, and any other third party payer, all medical or other information that is needed to determine the benefits payable for health services. I agree to pay the charges for the care are treatment rendered to me that are not covered by insurance including and reasonable collation fees required to collect delinquent accounts.

My Healthcare Provider, Insurer, Or Plan May Require A Physician Referral Or Prior Authorization And I May Be Obligated For Partial Or Full Payment For Physical Or Occupational Therapy Services Rendered.

Initials:_____

HIPAA Privacy Policy: I have been provided a copy of the HIPAA Privacy Policy for review and know that if I would like a copy of it to keep, I can request one.

Initials:_____

Cancel/No Show Policy: I have read and understand Dadez physical Therapy's Cancel/No Show Policy and know that if I would like a copy of it to keep, I can request one.

Initials:_____

Continue on Back

As part of working with my insurance carrier, I recognize that Dadez Physical Therapy may be provided with information about my insurance coverage, and that on occasion Dadez Physical Therapy may share some of this information with me. However, I understand and acknowledge that Dadez Physical Therapy is not responsible for the accuracy of any insurance coverage information shared with me, and that I am solely responsible for reviewing my insurance plan documents and /or working with my insurance carrier to determine the scope and details of any available insurance coverage. By signing below, I agree that I am responsible for the bill for any services rendered for myself or the patient for whom I am signing.

Patient's Printed Name

_____

Signature of Patient or Patient Representative or Parent/Legal Guardian of Minor. Date:

_____ _____

If Signature of Patient Representative of Parent/Legal Guardian of Minor, indicate relationship to patient:

_____

REQUIRED SIGNATURE (UPDATE ANNUALLY)

DADEZ PHYSICAL THERAPY, INC.
471 S. ARCH AVE. SUITE 1
NEW RICHMOND WI, 54017
PHONE: (715)-246-3809
FAX: (715)-246-7139

DADEZ

Financial Policy

Review Your Benefits: We recommend that you call you insurance company with any specific questions related to your policy relating to **outpatient physical therapy** benefits. You need to be aware of and understand your policy's deductible, co-payment, coinsurance, visit limitations, effective annual calendar renewal date, and any pre-authorization requirements. As a courtesy, we will also verify your coverage, but we will not guarantee the accuracy of the information we receive. Your insurance policy is a contract between you and your insurance company. You are responsible to know your level of coverage, and you are ultimately responsible for the full payment of you bill.

Insurance Information: We will submit claims to your health insurance company for you. You are responsible for payment of any deductible, co-pay, and co-insurance as determined by your contract with your insurance company. You are responsible for any amount or any services not covered by your insurer

Medicare: Dadez Physical Therapy is a Medicare-approved provider of outpatient physical therapy. All Medicare policy holders have a maximum benefit for outpatient physical therapy services. We will monitor your visits and make you aware as you near the maximum allowed by Medicare.

Workers Compensation: If you are claiming worker's compensation you must provide us with a copy of your personal insurance card. We will confirm your authorization with your case adjuster or case manager. In the event payment for your claim is denied by your worker's compensation carrier, we will file the claims with your personal insurance policy. If your claim is denied by your personal insurance, you are responsible for the full payment of your bill.

Auto Accidents: Auto insurance claims will be billed to YOUR auto carrier. If your auto PIP exhausts, we will bill your health insurance that you have provided. If you wish to not have your health insurance billed, you will be responsible for all charges.

Minors: A parent or legal guardian must accompany the minor patient at the time of the initial visit. The parent or legal guardian is responsible for full payment as outlined in the above financial policy. The parent or legal guardian that accompanies the minor patient to the clinic will have full responsibility for the payment should any dispute arise.

Supplies: Occasionally, therapy supplies are recommended to expedite and aide in your recovery. Unfortunately, most insurance companies do not cover these items. Therefore, if your therapist suggests these items, it will be your responsibility and your decision to purchase these items. **Used or opened items are non returnable/refundable**. Supplies are to be paid for at the time of service.

Payment: We accept cash, check, VISA, and Mastercard and **Discover**. There will be a $20.00 service charge for all returned checks. If you have insurance, balances will be considered current from the date your insurance pays its portion. After that, the payment is due upon receipt of a statement from our office. We will work with you to set-up customized payment plan if necessary, please ask.

Your Statement: Patient statements will be mailed out monthly. As a courtesy, Dadez Physical Therapy will submit claims to your health insurance company after each visit, and we will apply payments received to your account. If needed, we will re-submit these claims to ensure payment of your benefit for covered services. In the event that repeated submission of claims does not satisfy your bill for the services rendered you will be responsible for the full payment of your bill. In addition, any remaining balance after your health insurance has paid is your responsibility.

Continue on Back

PAYMENTS DUE AT THE TIME OF SERVICE

1. Co-pays that are required by your insurance policy are due at the time of service.
2. If you are a **Non-Insurance-Fee-for-Service** patient, full payment must be received at the time of service.
3. Cancellation or no-show fees ($40.00) are due at the time of your next scheduled session
I have read and understand the above Financial Policy and agree to the conditions listed.

_____

Print Patient Name Printed Name of person authorized to consent

_____

Date Signature of Patient or Parent/Legal Guardian of Minor

DADEZ PHYSICAL THERAPY, INC.
471 S. ARCH AVE. SUITE 1
NEW RICHMOND WI, 54017
PHONE: (715)-246-3809
FAX: (715)-246-7139

Patient Questionnaire

Name:_____Referring Physician:_____
Today's Date:_____Age:_____ Occupation_____

1. For what problem(s) or area of your body are you being seen for in Physical Therapy? _____
2. When did the problem begin? Please be specific. (If the condition is longstanding or on-going, please give the most recent date of the exacerbation or worsening of the condition) _____
   _____
3. How did this problem begin?_____
   _____
4. What other treatments have you had for this problem? (such as chiropractic, surgery, and other therapies as well as dates received) _____
   _____
5. Have you fallen in the last year? YES NO
6. Is the cause of this problem work-related? YES NO
7. Are you pursuing a lawsuit for compensation? YES NO
8. Have you had any previous surgeries? YES NO
   If YES, please list the surgeries you have had: _____
   _____
9. If you have received any of the following diagnostic tests for your condition, please circle the tests below:

   X-Rays CAT Scan CAT Scan
   EMG Bone Scan Lab Tests

10. If you have/had any of the fallowing conditions/problems, please circle them below:

Heart Disease	High Blood Pressure	Cancer	Arthritis	Lymes
Allergies	Diabetes	Pregnancy	Metal Implants	Loose Joints
Pacemaker	HIV/AIDS	Latex Senitivity	Visual Impairment	Hearing Impairment
Tendency to Bleed Easily	Tape Allergies	Fractures	Asthma	Mono
Smoker Past or Present	Pneumonia	Sinus Infection	Tailbone Hit	Bowel or Bladder Issues

11. Please circle the best way for us to help you learn a home exercise program

    Verbal Instruction Written/Illustrated Instruction Demonstration

12. Please list three things that you are unable to do or have difficulty doing because of the condition stated in question 1. (i.e. rolling over in bed, bender over to tie shoes, combing hair, sitting for longer than…)
    1. _____
    2. _____
    3. _____
13. How much time are you willing to commit to a daily exercise routine to promote healing and wellness?

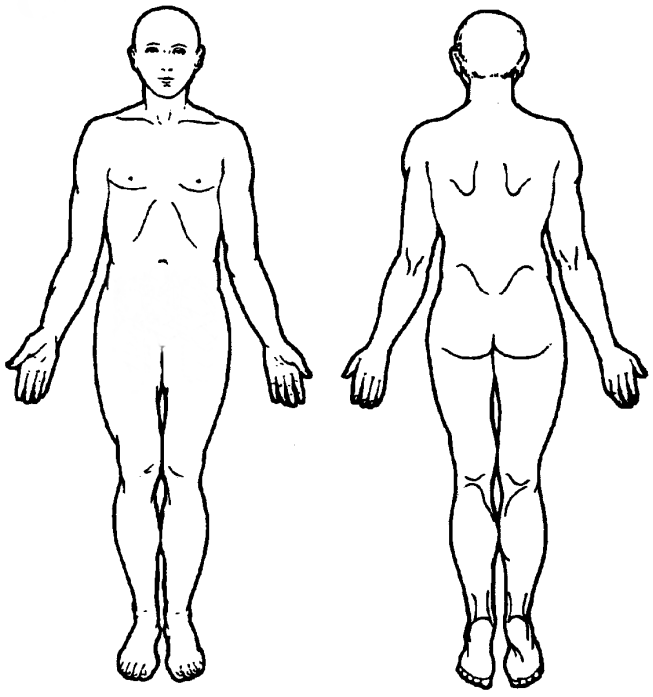
    ___15min ___30min ___45min ___60min ___Over an Hour per Day
14. Please rate you pain on a scale from 0-10. (0= No Pain, 10 = Requires Emercency medical attention)

    Least pain rating:_____ Frequency and Duration:_____

    Most pain rating:_____ Frequency and Duration:_____
15. Please circle the words or phrases below that best describe your pain:

Constant	Occasional	Burning	Throbbing	Aching
Sharp	Tingling	Pins&Needles	In one Place	Moves Around
Better with Activity	Worse with Activity	Pain at Rest	Other:	

Please Mark where you have your Symptoms/Pain on the Picture to the right:



DADEZ PHYSICAL THERAPY, INC.
471 S. ARCH AVE. SUITE 1
NEW RICHMOND WI, 54017
PHONE: (715)-246-3809
FAX: (715)-246-7139

DADEZ

Medications List

Patient's Name:	Date of Birth:	Today's Date:

Allergies/Adverse Effects to Medications:

1. Complete the patient information in the section above
2. In order to provide optimal care it is important for us to maintain an up-to-date list of all your medications (Over the counter, prescription, herbal or natural medications, vitamins and minerals)
3. To help us obtain this information, please fill out the chart below.

Name of Medication (Brand or Generic)	Dosage	Reason for taking	Frequency	Route oral, injection, ect

DADEZ PHYSICAL THERAPY, INC.
471 S. ARCH AVE. SUITE 1
NEW RICHMOND WI, 54017
PHONE: (715)-246-3809
FAX: (715)-246-7139

DADEZ

Record Release

I am aware that Dadez Physical Therapy may release any/all medical information acquired in the course of treatment to myself, my insurance company, employer, QRC, or other healthcare agencies, professionals, or persons who may provide healthcare services deemed necessary for continuing my medical care.

Initials _____

Please also verbally release medical information regarding my physical therapy care to the following individual(s) listed below: (ie., family members, coaches, trainers, ect.) It is not necessary to list physicians or insurance companies here.

Initials _____

Name	**Relationship**	**Phone Number**
_____	_____	_____
_____	_____	_____

Patient's Printed Name _____ **D.O.B.** _____

Signature of Patient
or Patient Representative
or Parent/Legal Guardian of Minor _____ **Date** _____

If signed by patient representative
or parent/legal guardian, indicate relationship to patient: _____

☐ MRI Report of _____ ☐ History/Physical

☐ X-Ray Report of _____ ☐ Laboratory Data

☐ CT Report of _____ ☐ Therapy Eval/ Discharge

REQUIRED SIGNATURE (UPDATE ANNUALLY)

REQUIRED SIGNATURE (UPDATE ANNUALLY)

DADEZ PHYSICAL THERAPY, INC.
471 S. ARCH AVE. SUITE 1
NEW RICHMOND WI, 54017
PHONE: (715)-246-3809
FAX: (715)-246-7139

Privacy Notice

****

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

****

I. Use of Medical Information by Dadez Physical Therapy, Inc.

Dadez Physical Therapy, Inc. (DPT, Inc.) is permitted to use private health information (PHI) about you for the purpose of providing treatment to you, for the purpose of obtaining reimbursement from third parties for the treatment DPT, Inc. provides to you, and to conduct our normal daily business activities. PHI is any information that specifically identifies you. The uses of PHI may include but are not limited to submitting copies of records by DPT, Inc. billing personnel for purposes of submitting bills and claims to insurance companies, health plans, Medicare, Medical Assistance, and other payers, and for the purpose of appealing denials of reimbursement by third parties for the services provided by DPT, Inc. DPT, Inc may disclose your private medical information to business associates who agree to comply with DPT, Inc.'s private health information policies. DPT, Inc. may disclose your private health information to other health care providers in connection with health care treatment they provide to you. DPT, Inc. may submit your private health information to the Medicare or Medical Assistance programs, for the purpose of health oversight activities, audits, investigations, and claims processing. DPT, Inc. personnel may also review your records for the purpose of evaluating the effectiveness of the treatment, conducting outcomes studies, and evaluating the skills of individual therapists.

DPT, Inc. will not disclose medical information about you for purposes not described in paragraph I above without first obtaining your prior written authorization. In the event you sign an authorization for release of your medical information you have the right to revoke the authorization at any time.

II. Your Rights

You have the right to request that restrictions be placed upon the use of you health care information but DPT, Inc. does not necessarily have to agree to those restrictions. You have the right to receive confidential communications of protected information. If you desire alternative means of communication please inform the therapist and DPT, Inc. will make reasonable attempts to accommodate you.

You have the right to inspect, copy and amend your protected health care records. You have the right to amend your health records pursuant to 65 C.F.R. 164.526. You have the right to receive an accounting of disclosures of protected health information. If you receive electronic copies of protected health information you have the right to receive paper copies.

DPT, Inc. is required by law to maintain the privacy of your records and to follow its policies regarding maintaining this privacy. You are entitled to notice if DPT, Inc. changes these policies.

You have the right to file a complaint if you believe these privacy policies have been violated. Complaints should be sent to Dadez Physical Therapy, Inc. 571 S Arch Avenue, Suite 1, New Richmond, WI 54017, or you can call (715) 246-3809

DADEZ PHYSICAL THERAPY, INC.
471 S. ARCH AVE. SUITE 1
NEW RICHMOND WI, 54017
PHONE: (715)-246-3809
FAX: (715)-246-7139

Cancelation/No Show Policy:

How It Affects You

Thank you for choosing Dadez Physical Therapy as your physical therapy provider. We are sincerely committed to helping you meet your goals of therapy. In order to do this, it is important that you attend all scheduled therapy appointments. Consistent attendance allows you and your therapist to progress your treatment program which will result in quicker recovery and better outcomes

We realize that there are times when unforeseen circumstances make it impossible to attend your scheduled appointment. If this happens, please give us as much notice as possible so we can reschedule the time for another patient and find another time for your appointment. Canceling an appointment with short notice or not showing up for an appointment, takes up clinic time that could benefit another person.

In order to enforce this policy, **you may be charged $40** if you cancel an appointment less than 24 hours before your appointment time, or do not show up for an appointment. Canceling or “no showing” for more than three appointments will unfortunately limit your ability to schedule advanced appointments and may result in allowing same day scheduling only.

We want to make your physical therapy experience as beneficial as possible and your commitment is a very important part of this. If you know you are going to have a difficult time making your appointments, please discuss this with you therapist. We will try to accommodate your needs.

Thank You