VeloFit Physical Therapy New Patient Intake Form

Patient Demographics

*First Name: ______________________________

*Last Name: ______________________________

*Date of Birth: (___/___/_______)

Address: ______________________________

City: ______________________________

State: ______________________________

Postal Code: ______________________________

*Email Address: ______________________________

*Phone Number: (_____)_____-_________

Occupation: ______________________________

*Emergency Contact: ______________________________

*Emergency Contact Number: (_____)_____-_________

*Primary Physician/Referring Doctor: ______________________________

How did you hear about us?

- ❑ Friend _________________
- ❑ Instagram
- ❑ Facebook
- ❑ Twitter
- ❑ Event
- ❑ YouTube
- ❑ Other __________________

Medical History

*Check all that apply:

❑ Heart Disease	❑ Arthritis	❑ Cancer
❑ Dizziness	❑ Nausea	❑ Skin Condition
❑ Currently Pregnant	❑ Headaches	❑ Kidney Ailments
❑ Hearing Aid	❑ Pacemaker	❑ Diabetes
❑ Recent Weight Loss	❑ Double Vision	❑ High Blood Pressure
❑ Night Pain	❑ Metal Implants	❑ Intra-Uterine Device
❑ Implants/Augmentation	❑ Osteoporosis	❑ Trouble Speaking/Swallowing

*Any other medical history not listed above? ___________________________________

____

*List any allergies: ______________________________

*List any medications you are currently taking: ______________________________

*Background/History of any major injuries or surgeries: _________________________

Pain Pattern and Description

*Main reason for visit: ____

*Location/Symptoms you are currently experiencing: _________________________

*Rate your level of pain from 0 to 10 (0=no pain and 10=worst possible pain): _______

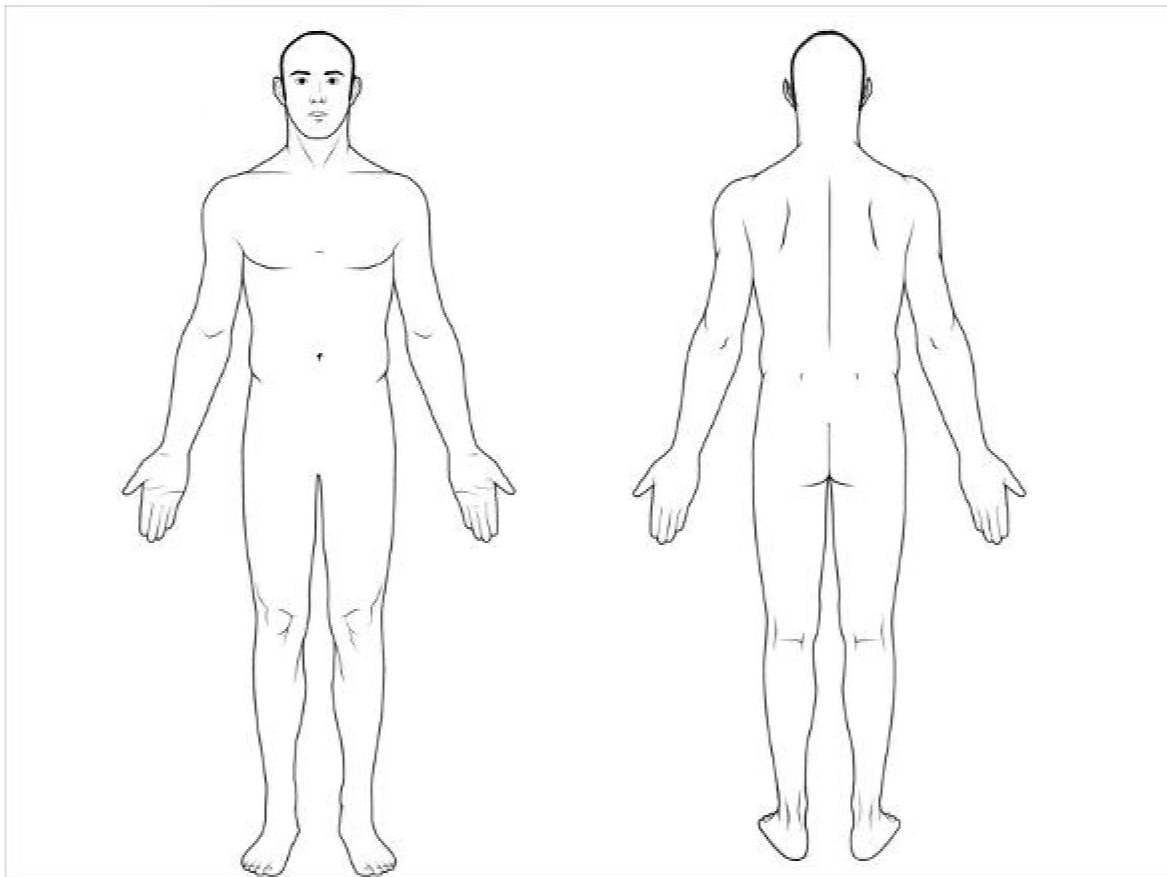
*If you were able to describe your pain what would it be?

- ❏ Dull ache
- ❏ Sharp
- ❏ Numb
- ❏ Throbbing
- ❏ Tension
- ❏ Other _________________

What makes the pain improve? ____

What makes the pain worse? ____

Please shade in areas where you have pain or discomfort



Consent to Assessment 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 to accelerate and reduce the length of recovery. Physical therapy is provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

VeloFit, LLC 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 planned 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 your treatment.

Your response to physical therapy intervention varies from person to person. Therefore, **VeloFit, 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 that you are seeking treatment for**. The number of treatments needed and recovery time can vary due to the age of 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.

VeloFit 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 instruct on new techniques. All procedures will be explained to the client prior to performing. There is a small risk that strength and conditioning may cause an increase in symptoms but this should not last for more than 24 -48 hours.

By signing below, I do hereby agree and give my consent for VeloFit, 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 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 Kur Sohn, PT, DPT, OCS of VeloFit, 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 stop my request for treatment before any procedure or test.

❏ I have read, understand, and agree with the Consent to Assessment and Treatment

X______________________ **X________________**

Signature of Patient/Legal Guardian **Date**

Financial & Payment Policy

Kur Sohn, PT, DPT, OCS of VeloFit, LLC is not a preferred provider for insurance companies for physical therapy services. Instead, VeloFit is an out-of-network (OON) provider and a cash-based practice. By not having a preferred provider or contracted status with insurance companies, we do not have to limit the time or quality of the treatment we provide to patients secondary to insurance company restrictions or raise our service rates to pay for billing services.

Prior to your first scheduled physical therapy appointment, call your insurance company to completely understand your physical therapy benefits. *Please refer to the Out-of-Network Insurance Benefits Reference Sheet* to help you ask the insurance company the right questions about your physical therapy benefits. At the time of service and payment, you will receive a written statement which you can submit to your insurance company for their consideration of reimbursement to you. VeloFit, LLC will be more than happy to provide chart notes or other documentation to help facilitate the process at your request. The amount of reimbursement you receive will vary according to the terms of your insurance policy. Some companies may reimburse you at 80%, or higher or lower, and some may not reimburse you at all. VeloFit, LLC cannot make guarantees or estimates regarding what reimbursement your plan allows. By signing below, the patient agrees 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.

Medicare and Medicaid patients: VeloFit, LLC does not accept Medicare or Medicaid and patients cannot be reimbursed for visits.

Injury prevention and strength and conditioning services will not be able to be submitted for insurance reimbursement but may be able to be credited toward a wellness credit if your insurance company offers this. It is your responsibility to check with your insurance company about this potential benefit.

VeloFit, LLC accepts **cash, check, or credit card at the time of service** for initial evaluation or follow-up visit. Upon completion of the initial evaluation, the therapist will recommend the most appropriate plan of care.

*** **Patients must prepay for physical therapy and/or strength and conditioning packages to be eligible for package discounts.**

I understand that I am entering into a private payment contract with VeloFit, LLC (herein as "VeloFit Physical Therapy"). Payment is expected promptly, and at the time service is rendered. I am responsible for all charges, regardless of insurance coverage. I understand that VeloFit is not a Medicare or Medicaid Provider; therefore, VeloFit will not submit insurance claims on my behalf, and I cannot submit a self-claim for reimbursement on my own behalf to either Medicaid or Medicare. I can, however, submit self-claims for reimbursement to my commercial insurance company. I understand that VeloFit still expects prompt payment for all services rendered, regardless of any contract terms I have with my insurance company.

X________________________________ **X**______________

Signature of Patient/Legal Guardian **Date**

Release of Liability

By checking the box below and signing this form, you hereby release VeloFit Physical Therapy, LLC and any other employee or subcontractor from any responsibility or liability due to your participation in physical therapy, massage therapy, or personal training program. Any legal action involving any treatment at VeloFit Physical Therapy shall be governed by and construed in accordance with the laws of Virginia.

You are fully aware that you are participating in these sessions at your own risk and will not hold anyone referenced above responsible in the event of your incurring an injury or exacerbating any previously existing conditions. If you have any medical conditions, you have consulted with your physician to make sure that physical therapy, massage therapy, and/or personal training is appropriate for you to participate in.

- ❏ I have read, understand, and agree with the Release of Liability

Privacy Policy

I understand that VeloFit Physical Therapy, LLC will maintain my privacy to the highest standards and may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment.

Your permission is required in order to release any of your treatment details, and for us to obtain information from your previous/current healthcare providers.

- ❏ I have read, understand, and agree with the Privacy Policy
- ❏ I authorize VeloFit Physical Therapy to release and obtain medical/health records from all practitioners concerned with my care
- ❏ I DO NOT authorize VeloFit Physical Therapy to release and obtain any of my medical/health records from and practitioners concerned with my care

Cancellation and No-Show Policy

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

H o w e v e r , we understand that circumstances arise which cause you to cancel your appointment. It is required that all cancellations occur at least 24 hours prior to your scheduled appointment time. **If you cancel your appointment less than 24 hours in advance, you will be will pay a cancellation fee of $50 for physical therapy services and $30 for strength and conditioning sessions.** You will be asked to provide a valid credit card when scheduling 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 charged 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 per the**

discretion of VeloFit, LLC. *I verify that I have read and understand the above written policy statements.*

X_______________________________ **X______________**

Signature of Patient/Legal Guardian **Date**

Newsletter Policy

As a client or patient of VeloFit LLC, you will be automatically signed up to receive our monthly newsletter using the email provided on the "Patient Information 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 consent to being automatically signed up for the monthly newsletter.

If you wish NOT to be signed up for this newsletter, please initial here: _________

Social Media

From time to time, your healthcare provider may request to post pictures or case studies pertaining to you on a social media outlet such as, but not limited to, Instagram, YouTube and/or Facebook.

I understand that VeloFit Physical Therapy uses social media for marketing and as an educational tool. I understand that when posted online, this information is in the public domain. Should I not feel comfortable having personal information released to the public, I have the right to decline any request of this nature by my healthcare provider. I understand I can terminate any past, present, and/or future social media content regarding me and any affiliates upon request at any time, acknowledging the potential difficulty of completely erasing distributed content once it's been released. Unless specifically requested not to by the patient for marketing reasons, all patient identifying information is removed as much as possible.

- ❏ I authorize VeloFit Physical Therapy to post my pictures or case study information in relation to my injury on social media outlets
- ❏ I DO NOT authorize VeloFit Physical Therapy to publicly use any of my pictures or case study information

Terms of Acceptance and Signature

- ❏ I accept and understand all terms in the sections outlined above

***Signature: _____________________________** **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 VeloFit, 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'sestablished"reasonableandcustomary/fair price"fortheservicecodesrendered.Thisprice 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'llneedthereferralcoordinator tosubmitarequestformoretreatment.

<u>Steps to Determine OON Therapy Benefits</u>

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

Name of Representative : ___________________________
Date/time:______________________________

- ★ Do I have Out-of-Network Benefits for Outpatient Physical Therapy?
  - ○ Yes
  - ○ No
- ★ Do I have a deductible?
  - ○ Yes
  - ○ No
  - ○ If yes, how much is it? _________________________________
  - ○ How much has already been met? _________________________________
- ★ Do I have a per calendar year plan or a per benefit year plan?
  - ○ If per benefit year, what are my dates of coverage? _________________________________
- ★ What percentage of coverage is my responsibility for seeing an OON or non-preferred provider? ______________________
- ★ Does my policy require a written referral or prescription from your primary care physician (PCP)?
  - ○ Yes
  - ○ No
  - ○ If yes, does it need to come from PCP or will a referral from any MD/physician, nurse practitioner (NP), Physician's Assistant (PA), podiatrist, or a specialist your PCP referred you to be accepted? ________________________________
  - ○ What is the name of the PCP on file? _______________________________
- ★ Does my policy require pre-authorization or a referral on file for outpatient physical therapy services?
  - ○ Yes
  - ○ No
  - ● If yes, so they have one on file?
    - ○ Yes
    - ○ No
  - ● What is the expiration date? ________________________
  - ● Is there a $ or visit limit per year?
    - ○ Yes
    - ○ No
    - If yes, what is it? _________________________
- ★ Do you require a special form to be filled out to submit a claim?
  - ○ Yes
  - ○ No
- ★ What is the mailing address where I should send claims and reimbursement forms?____ ________________________________

★ Is there an online website where I can submit my claim online? If yes, what is it?_______________________________________