Danni Jones Physical Therapy Policies

Welcome to Danni Jones Physical Therapy!

We are pleased that you have chosen to allow us to serve you for your Physical Therapy needs. We strive to provide highly skilled, compassionate, and progressive physical rehabilitation with an emphasis on one on one care.

Financial Policy

1. All Co-payments, Co-insurance and Deductibles are due at the time of service for all patients.
2. If you are the guarantor for a minor's account please make arrangements with our Front Desk Personnel regarding payments for services.
3. Forms of payment include: Cash, Check, Debit Card, Visa, American Express, Discover, or MasterCard.

Insurance Benefits Policy

1. Danni Jones PT will bill your primary and secondary insurance carriers as a courtesy to you. However, patients who have health care insurance should understand that charges for professional services are charged to the patient and not to the insurance company. **You are ultimately responsible for payments for all services rendered.**
2. To enable us to provide this service for you, you must:
   a. Provide us with necessary and correct insurance information for billing to be done correctly and timely.
   b. Notify us if any part of your insurance coverage information changes during the course of treatment.
   c. If you elect not to provide all necessary information for billing your insurance company you will be treated as a cash patient and will receive a "superbill" that you may use to submit your bills directly to your payer for reimbursement.
3. You agree to pay for all charges that are **not covered** by your insurance plans.

4. If charges billed to your insurance company on your behalf are not paid by your insurance company within a reasonable time, the overdue amount will become your full responsibility and payment will be due at that time. (It will then become your responsibility to resolve the outstanding issue with your insurance company and receive your reimbursement from them.)
   a. Most insurance companies pay within 3-4 weeks.
   b. You can help facilitate payments on your account by reviewing your Explanation of Benefits (EOB) and responding to any requests in a timely manner. Please notify us immediately if a payment is denied.

Patient Billing Process:

We will make every attempt to process all of your claims in a correct, efficient, and timely manner.

1. Once your insurance company begins making payments on your account, you will receive a monthly statement to inform you of your account status.

No Shows

Our time is valuable in order to properly serve patients in the best manner they need, each appointment is important, therefore we ask that you notify us at least 24 hours in advance if you know you cannot make your appointment. That way we can give your time to another patient in need. If a series of NO Shows happens then a $25 charge will be given.

Acceptance of Financial Policy:

1. I have read and understand the financial policy of Danni Jones Physical Therapy.
2. I agree to assign insurance benefits to Danni Jones Physical Therapy whenever necessary.
3. I agree to pay any and all balances due and understand that Danni Jones Physical Therapy will not hold accounts for payment.
4. I understand that if I do not pay my account as designated, my debt may be presented in Small Claims Court for judgment, or sent to a professional collection agency.
5. I accept the No Show Policy and will give proper advanced notification if I need to cancel my scheduled appointment.

By my signature below I agree to be financially responsible for payments of all services received.

____ ____________
Patient's Signature Date

____ ____________
Signature of the person responsible for the bill if not the patient or if patient is a minor Date

Thank you for choosing us for your Physical Therapy needs.

Patient Information

Name ________________________ ____________________**Soc. Sec. #**______________

Last name *First Name*

Address____

City_____________________**State**____ **Zip**________**Home Phone**____________________

E-mail_________________________________ **Cell**__________________________

Would you like to receive appointment reminders via **Text** Yes/No **Email** Yes/No

Sex M__ F___ **Age**_______ **Birthdate**______________**Marital Status**__________________

Employer/School____

Occupation/Grade_______________________________**Work Phone**___________________

Insured Name _____________________________________**Soc. Sec. #** ________________

Last Name *First Name*

Insured Birthdate __________________________

Person responsible for the account____

*please list attorney if applicable here

In case of emergency who should be notified_______________________________________

Referred by _________________________________

PAST MEDICAL HISTORY FORM

Patient Name:____

Date:________________

Age: _________________

Have you received physical therapy at another location this year? □ Yes □ No

If yes, how many visits have you received? ____________

Date of next physician's visit: ________

Date of injury / onset:_______________

Are you presently seeing an attorney for this injury? □Yes □ No

If so, please provide your attorney's information:

____

____

Have you ever had these symptoms before? □Yes □ No

Check which apply to your symptoms:

- □ Work related injury
- □ Recurrence of previous injury
- □ Motor vehicle accident
- □ Injury related to lifting
- □ Injury related to falling
- □ Cause unknown
- □ Athletic / recreational injury
- □ Other: __________________

Please List Your Surgical History__________________________________

____

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____

Do you have, or have you had any of the following? If you answer yes please give a brief description in the space provided to the right.

	Yes	No
Diabetes	☐	☐
Chest Pain / Angina / Short of Breath	☐	☐
Heart Disease/Heart Attack	☐	☐
High Blood Pressure	☐	☐
Poor tolerance to Cold	☐	☐
Allergies	☐	☐
Heart Attack	☐	☐
Seizures	☐	☐
Pacemaker	☐	☐
Metal Implants/Joint Replacement	☐	☐
Headaches Dizziness / Fainting	☐	☐
Kidney Problems	☐	☐
Osteoporosis or Recent Fractures	☐	☐
Are you pregnant?	☐	☐
Surgeries	☐	☐
Cancer	☐	☐
Bowel / Bladder Dysfunction	☐	☐
Asthma / Breathing Difficulties	☐	☐
Rheumatoid Arthritis	☐	☐
Liver / Gallbladder Problems	☐	☐
Smoking	☐	☐

Stroke/CVA □ □

Tested Positive for HIV □ □

Other:___________________

Is there any other information regarding your medical history we should know?

Are you presently taking Medication? □ Yes □ No

If yes, please list what medications and for what condition____________

____

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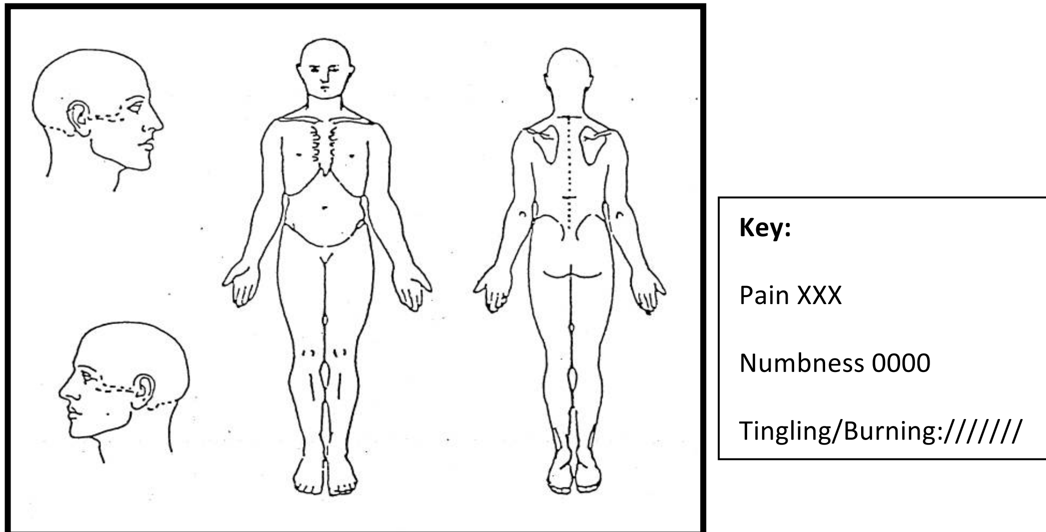
Do you participate in any sports, exercise, or activities regular? □ Yes □No

Please indicate below where your symptoms are located.



Please rate **best**, **average**, and **worst** pain values from 0 to10.

(0=no pain & 10=emergency room pain)

At worst pain _____ Current pain ______ At your best _______