Patient Name: _____

DANNI JONES
PHYSICAL THERAPY
PILATES AND WELLNESS

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 and timely manner. 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 advance 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

Would you like to receive electronic billing via Email? Email □Yes □ No

Sex □ M □ F **Age**_____ **Birthdate** _____ **Marital Status** _____

Employer/School _____ **Occupation/Grade** _____

Work Phone _____

Primary Insurance Holder _____ **DOB:**_____
Last Name *First Name*

Secondary Insurance (if applicable) _____
Last Name *First Name*

Person responsible for the account _____
(Please list attorney if applicable here)

In case of emergency, who should be notified _____

How did you hear about Danni Jones Physical Therapy?

□ Friend: _____ □ Social Media

□ Doctor: _____ □ Search Engine (i.e. google)

□ Website □ Other: _____

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:

_____

_____

For Medicare Patients Only:

Have you or are you currently receiving Home Health? □Yes □ No

If so, approximate date of discharge from Home Health? _____

PAST MEDICAL HISTORY FORM

Have you ever experienced 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

Please List Your Surgical History_____

_____

_____

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?

_____

_____

_____

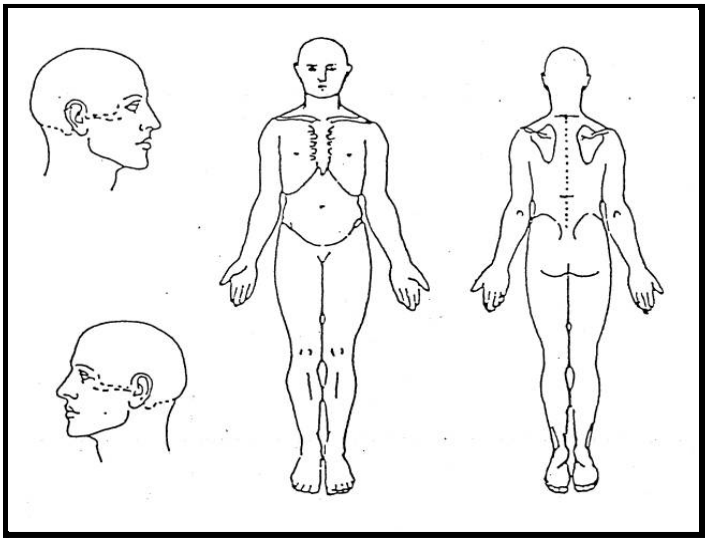
Are you presently taking Medication? □Yes □ No

If yes, please list what medications and for what condition _____

_____

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

Please indicate below where your symptoms are located.



Key:

Pain XXX

Numbness 0000

Tingling/Burning:///////

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 _____

INFORMED CONSENT:

I understand that as a patient of Danni Jones Physical Therapy I am choosing to participate in a physical therapy evaluation at my own risk. An evaluation includes medical history review and physical examination.

I understand that following the evaluation the complete findings of the evaluation, the treatment options and risk, and the prognosis will be communicated as clearly as possible to a level I can understand by my physical therapist and that I have the right to choose whether I participate.

I will receive the most effective care the clinic provides. I have the right to accept medical care or to refuse treatment to the extent permitted by law and to be informed of the medical consequences if I refuse treatment.

I understand that if I refuse recommended treatment, Danni Jones Physical Therapy has the right to terminate the relationship with me.

I will be informed if Danni Jones Physical Therapy wishes to participate in or perform any research or educational projects that would affect my care.

Patient Signature: _____ Date: _____

Notice of Privacy Practices Policy (HIPAA):

This is a policy providing information regarding the handling of your personal information and medical history according to HIPAA requirements. This policy is available on our website with this link:
https://www.dannijonespt.com/downloads/notice_of_privacy_practices-hipaa.pdf
or you may request a copy.

Patient Signature: _____ Date: _____

CREDIT CARD SAVED

I give Danni Jones Physical Therapy permission to charge my credit card that is saved on file. The charge that will be made is for my daily charge, not my outstanding bill

Patient Signature: _____ Date: _____

___ Charge Each Visit

___ Charge My Card One Time for My Visits for The Week