T. 907-245-1245 | F. 907-245-1244 | 1045 E Klatt Rd, Anchorage, AK 99515 | www.ajointeffortpt.com

- Please arrive to your initial appointment at least 15 minutes early. For all following appointments, please arrive 5 minutes prior to you scheduled appointment time. To avoid waiting unnecessarily remember to check in with the front desk upon arrival.

- It is your responsibility to notify your insurance company that you will be attending Physical Therapy. **We recommend that you also inquire as to your particular benefits and coverage. See enclosed verification form with important questions to ask your insurance company**. Any charges not covered by your insurance company will be your financial responsibility. Joint Effort PT is not responsible for tracking specific insurance coverage/benefits.

- We bill both primary and secondary insurance as a courtesy to our patients. We allow 30 days for each. If your insurance does not pay within the allotted time frame, the balance becomes your responsibility. It has been our experience that insurance companies do tend to find reasons to delay payment. It is your responsibility to communicate with your insurance company regarding your claim status. You are your best advocate in dealing with your insurance company as the contract is specifically between the two of you and we are not part of that relationship. Please be prepared to pay your balance should your insurance company delay payment.

- We are preferred with Blue Cross and Aetna; however, you will be responsible for deductibles, co-pays and non-covered services.
  - **Some insurance plans do require pre-authorization for Physical Therapy.** It is your responsibility to find out if your policy requires pre-authorization and to provide Blue Cross the information they may need to provide you the authorization to be seen.
  - **Some insurance plans have maximum therapy benefit limits.** It is your responsibility to track your visits if this is the case.

- **Certain supplies that may be beneficial to you are considered "non-essential" items by many insurance companies. We require supplies to be paid for when they are provided.** We do not bill insurance (private, workman's compensation, Medicare or Medicaid) for supplies. If you would like a receipt for your supply item we are happy to provide one.

Please feel free to ask questions about this document.
I have read the above guidelines and agree to the terms set forth by A Joint Effort PT.

Signature: _______________________________________ Date: ____________________

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Financial Policy

Medicaid:

- Copy of Medicaid Coupon required.
- Prescription from a referring physician is needed or documentation that you are under a physician's care.
- Supplies must be paid when provided, as we are not a Durable Medical Provider.
- Each Month Medicaid Coupon must be provided as proof of coverage.

No Show/Cancellation Policy:

- Your appointment time is reserved for you, by you. We appreciate 24-hour notice of cancellation. This enables us to offer the appointment to others. You may lose future scheduled appointments if you do not show. We appreciate your consideration of others.

I have read and understand the above financial policy. I understand that I am ultimately responsible for the payment on my account.

Signature: ______________________________________ Date: _________________

In the event that my treatment concludes and a refund is owed to me for an amount less than $5.00, I authorize A Joint Effort Physical Therapy to donate the money to a local charity.
_______________Please initial if you agree

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Patient Information Sheet:

Last Name: ________________________ First Name: _______________________ MI: _________

Mailing Address: ____ Zip: __________________

Billing Address: ____ Zip: __________________

Home Phone: ____________________ Cell: ____________________ Work: ___________________

Birth Date: ___________________ Sex: M / F Marital Status: _______________________

Social Security #: ____________________ Employer: ____________________________________

Email Address: ____

Emergency Contact / Phone Number: ______________________________ /__________________

Who May We Thank For Referring You? ____

Your Referring Physician: ___________________________ Next Appointment: _______________

Your Primary Physician: ____

Date of Injury or Onset of Pain: _______________________________________

Was Your Injury Auto Related? ____________ If yes, date of accident: _________________

Have You Ever Received Home Health Care? ___________ If yes, when and where: _____________

Were You Injured On the Job? ______________ If yes, please provide the following:

1. Employer at time of injury: ____
2. Employer/Human Resource Phone: ___________________________ / _______________
3. Employer Address: ____
4. Date of Injury or Onset of Pain: _______________________________
5. Work Comp Carrier: ____
   Adjuster: ___________________ Phone: __________________ Claim#: _______________

Insurance Information

Primary:
Insured's Name: _______________________ Relation to Patient: _____________
Insured's Social Security #:______________________ Insured's birthdate: ______________
Insurance Company Name: ______________________ Phone: _______________
Claim Mailing Address: ____
ID: ______________________________ Group #: __________________________

Secondary:
Insured's Name: _______________________ Relation to Patient: _____________
Insured's Social Security #:______________________ Insured's birthdate: ______________
Insurance Company Name: ______________________ Phone: ________________
Claim Mailing Address: ____
ID: _______________________________ Group #: __________________________

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Consent to Treat:

I hereby give consent for all Physical Therapy services provided by A Joint Effort Physical Therapy.

Signature: ______________________ Date: _________________

Benefit Assignment/Release of Information:

I authorize A Joint Effort Physical Therapy to furnish and receive information concerning my injury/illness and/or treatment to medical providers, guarantors or insurance carriers. I assign A Joint Effort Physical Therapy all payments for services rendered. I authorize A Joint Effort to release my medical information should the insurance company request it.
Signature: ______________________ Date: _________________

Acknowledgement: Receipt of Notice of Privacy Practices:

Please sign that you have been provided the opportunity to review the privacy practices as required by HIPAA. (Located at the front desk).

Signature: _______________________ Date: _____________________

Authorization to Release Health Information:

Insurance Company and referring provider do not require authorization under HIPAA, please use the following for a spouse, friend or someone in addition to insurance or provider)

Name:	Relationship To You	Start Date	End Date
_______________	_______________	_________	________
_______________	_______________	_________	________

I authorize A Joint Effort PT to release my health information to the above individuals.

Signature: ________________________ Date: ________________

Name: ___________________________________ Date: ______________________ Age: ____________

Date of Injury or Onset of Pain: ___________________ Pain is chronic: ________ Pain is insidious: _______

Was a surgery performed? Yes______ No_____ If Yes, Date of Surgery: ______________________________

What type of surgery was performed? ____

Was there prior hospitalization? Yes_____ No______ Dates of hospitalization: ___________to____________

Do you have a history of falls: Yes____ No_____ If yes, dates of falls: ______________________________

What is the history of your present condition? (Date of Injury, onset of injury, etc.): ____________________

____

____

____

Have you had previous treatment for this condition? ____

What is your current level of function? ____

____

***Check those that apply*:**

Prior to your injury what areas were you independent in?

_____ Activities of Daily Living _____Self Care _____Work/Vocation

_____ Care giving _____Ambulation/Mobility _____ Community Integration Access

Additional Areas: ____

What are your functional limitations?

_____ Sleep _____ Self Care _____ Activities of Daily Living

_____ Reaching/Pushing Pulling _____ Lifting/Carrying _____ Sitting/Standing

_____ Bending/Squatting _____ Mobility/Ambulation _____ Community Integration/Access

Additional Limitations: ____

Aggravating Factors: ____ Sitting ____ Standing ____ Walking ____ Stairs Up ____ Stairs Down

____ Sit to Stand ____ Bending ____ Voiding ____ Laying ____ Coughing/Sneezing

Additional Limitations: ____

Are you currently employed? Yes_____ No______ If yes, what is your occupation? ___________________

Duty Level: _____ Sedentary ______Light _______Medium _____Heavy ______Very Heavy

Employment Status: Full Time_____ Part Time_____

Has your injury prevented you from working? Yes _____ No _____ Last day of work: ____________________

What is your primary concern or chief complaint regarding your injury? ______________________________

Restrictions and Pain Alleviators: _______Yes _______No

Pain Scale: 0 = None 5 = Moderate 10 = Extreme

	0	1	2	3	4	5	6	7	8	9	10
At worst:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Current:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At Best:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Pain Description:

_____ Burning _____ Sharp _____ Dull/Achy _____ Throbbing _____ Shooting

_____ Numbness/Tingling _____ Constant _____ Intermittent _____ Worse in AM _____ Worse in PM

Where is your pain located? ____

A Joint Effort Physical Therapy ***Patient Name:*** ____________________________________

Date: __________________________________

Medical History:

____ Allergies	____ Depression	____ Multiple Sclerosis
____ Anemia	____ Diabetes Mellitus Type 1	____ Osteoporosis
____ Anxiety	____ Diabetes Mellitus Type 2	____ Parkinson's
____ Arthritis	____ Dizzy Spells	____ Rheumatoid Arthritis
____ Asthma	____ Emphysema/Bronchitis	____ Seizures
____ Cancer	____ Fractures	____ Strokes
____ Cardiac Conditions	____ Gallbladder Problems	____ Thyroid Disease
____ Cardiac Pacemaker	____ Hepatitis	____ Tuberculosis
____ Cardiovascular Disease	____ High Blood Pressure	____ Vision Problems
____ Chemical Dependency	____ Incontinence	____ Circulation Problems
____ Kidney Problems	____ Currently Pregnant	____ Metal Implants
____ Headaches	____ Nausea/Vomiting	____ Fevers/Chills/Sweats
____ Muscular Weakness	____ Night Pain	____ Shortness of breath
____ Unexplained weight change		

Other conditions or precautions: ____
____

Surgical History:

Body Region: ____________________ Surgery Type: __________________ Date of Surgery: __________
Body Region: ____________________ Surgery Type: __________________ Date of Surgery: __________
Body Region: ____________________ Surgery Type: __________________ Date of Surgery: __________
Body Region: ____________________ Surgery Type: __________________ Date of Surgery: __________

Have you been seen any of the following:

___ Chiropractor	Date: _____________________	Reason: ______________________________
___ Osteopath	Date: _____________________	Reason: ______________________________
___ Naturopath	Date: _____________________	Reason: ______________________________
___ Physical Therapist	Date: _____________________	Reason: ______________________________

Have you had specific testing for this condition? (MRI's, X-Rays, Lab Tests, etc.) Yes ____ No ____

If yes, what were the results? ____

Medications:

Please list all over the counter, prescription, or any other medications you are currently taking. Please also list any herbal, vitamin, mineral, or dietary supplements you are currently taking.

Medication: _________________Dosage:________________ Reason for taking: ____________________________
Medication: _________________Dosage:________________ Reason for taking: ____________________________
Medication: _________________Dosage:________________ Reason for taking: ____________________________
Medication: _________________Dosage:________________ Reason for taking: ____________________________

____ I am not currently taking any medications.

How often do you experience stress? _____ Never _____Seldom _____Occasionally _____Regularly _____ Always

Do you smoke? Yes___ No___ If yes, how much per day? ____________________________________

Do you use alcohol? Yes___ No___ If yes, how many drinks per day? _______________________________

Do you use caffeine? Yes___ No____ If yes, how many cups per day? _______________________________

Types of caffeine used: Coffee______ Soda_______ Tea_____ Chocolate_____

Do you exercise regularly? Yes___ No___ If yes, what type of exercise? ___________________________________

Your current weight: ________________________________ Your current height: ___________________________

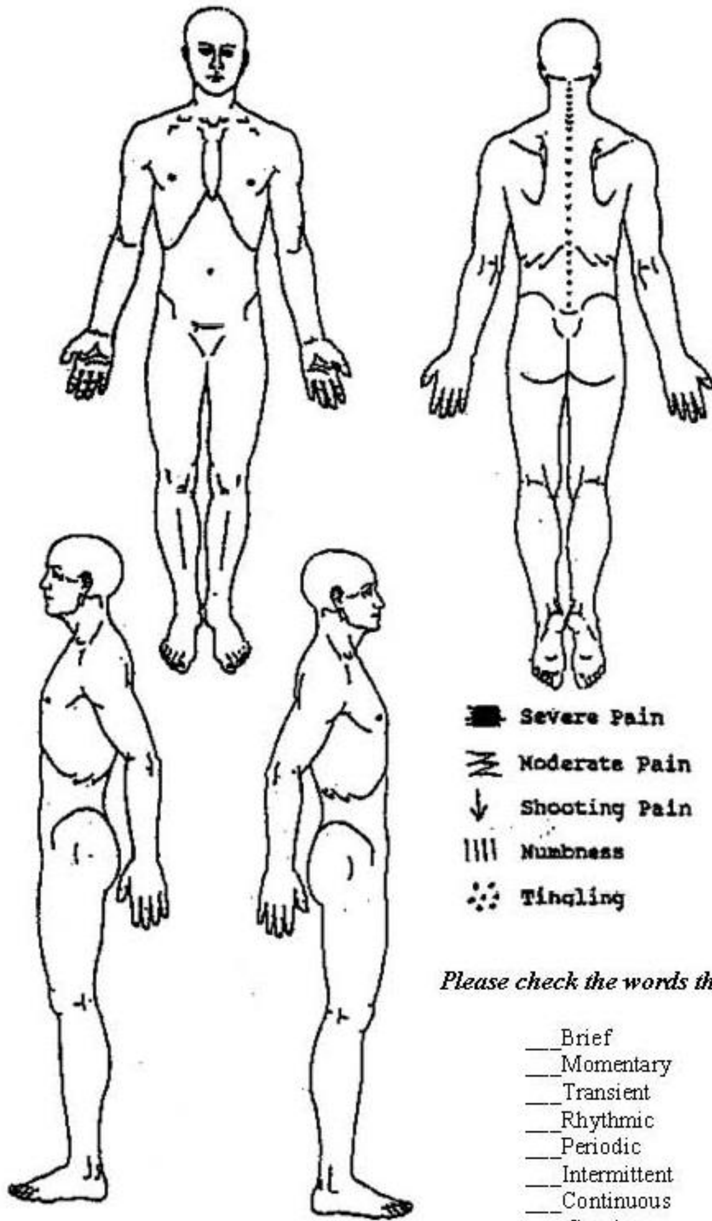
What goals would you like achieve in Physical Therapy?

A Joint Effort Physical Therapy

Patient Name: ______________________________

Date: ______________________________

Please draw your symptoms on the diagram using the key below:



Please check the words that apply to your pain:

___Brief
___Momentary
___Transient
___Rhythmic
___Periodic
___Intermittent
___Continuous
___ Steady
___Constant

Please rate your pain on the line below:

No Pain ____ Worst Possible Pain