AJOINTEFFORT
PHYSICAL THERAPY

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.

- VA patients must obtain a pre-authorization by VA before treatment can begin. The patient must contact VA and have them fax us an authorization for treatment. If this is not available at time of service, the patient will be self- pay.

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

Private Insurance:

- A copy of your insurance card with the billing address, ID number and group number.
- Payment is due at the time of service. Your will be asked to pay your portion when the services are rendered (deductible, co-insurance, copay). We will bill your insurance as a courtesy.
- If you have only one insurance carrier, we allow 30 days for full payment. It is in your best interest to periodically contact your insurance to ensure they are processing your claim.
- **With one insurance carrier, balance is due after 30 days if not paid by insurance carrier**.
- If you have 2 insurance carriers, we allow 30 days for each insurance to respond with payment. It is in your best interest to periodically contact your insurance to ensure they are processing your claims.
- **With 2 insurance carriers, balance is due within 60 days if not paid by the insurance carriers.**
- If your insurance carrier "pends" your claim for any reason (accident questionnaire, other insurance information, etc…) it is in your best interest to respond immediately. We treat a "pend" notice like a denial and request payment.

Service fees are added to any aged account at a rate of 1.5% per month. Any accounts remaining unpaid after a deemed reasonable amount of time will be sent to Cornerstone Credit Services**. The patient will be responsible for any collection fees in addition to the balance of the account.**

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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Insurance Verification Form:

Please Take this home with you, contact your insurance carrier and verify your coverage. At your next visit, please bring a copy to Joint Effort; we will keep it in your records. Feel free to discuss any limitations or concerns with your therapist, so you can plan your treatment accordingly.

Note: It is the patient's responsibility to verify insurance coverage. A Joint Effort Physical Therapy is not responsible for misinformation given by the patient or insurance company.

Patient Name: (please print) _____
Insurance Company: _____
Date Verified: _____ Name Of Representative: _____

Questions To Ask Your Insurance Company to Verify Coverage of Physical Therapy:

Tell them that you are calling to verify our patient physical therapy benefits:

1. Is a doctor referral necessary? _____
2. Annual deductible amount $_____ How much has been met? $_____
3. What is the out of pocket limit? $_____ How much has been met? $_____
4. Is there a maximum benefit for Physical Therapy? _____
5. What percent of treatments are covered? _____
6. Is there a co-pay? _____
7. Is pre-authorization required? _____

Signature: _____ Date: _____

Glossary of Terms

Coverage: the range of health-care services and supplies for which your health plan provides benefits.
Benefit: the portion of the cost for covered health-care services and supplies that your health plan is responsible for paying.
Out-of-Pocket expenses: costs that are paid by you, not your health plan – such as the following

Coinsurance: the percentage of the cost you will pay for a covered medical service, after your health plan has paid its portion.

Copayment (copay): a set fee your health plan may require you to pay your health-care provider at each visit for a certain covered services.

Deductible: a fixed amount your health plan may require you to pay for certain covered services and supplies each year before your health plan starts paying specified benefits. Copays are not credited toward your deductible.

Provider: a doctor, hospital, or other medically licensed or medically certified person or facility that provides health-care services or supplies.

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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: _____

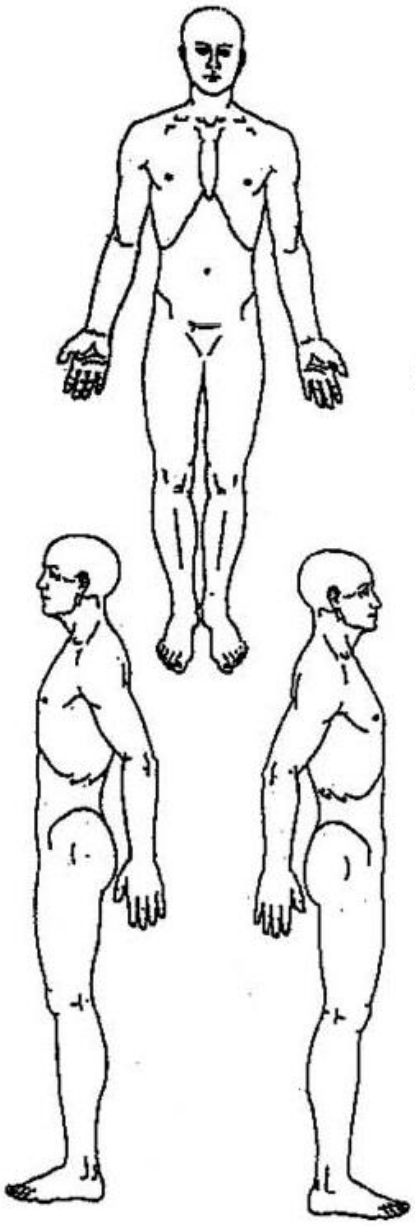
What goals would you like achieve in Physical Therapy?

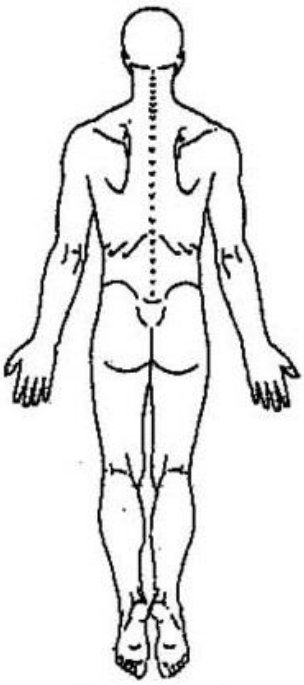
A Joint Effort Physical Therapy

Patient Name: _____

Date: _____

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





Severe Pain

Moderate Pain

Shooting Pain

Numbness

Tingling

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