



T. 907-245-1245 | F. 907-245-1244 | 1045 E Klatt Rd, Anchorage, AK 99515 | [www.ajointeffortpt.com](http://www.ajointeffortpt.com)

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- Please arrive to your initial appointment at least 15 minutes early. For all following appointments, please arrive 5 minutes prior to your 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

#### VA:

- Prior authorization for treatment needs obtained by the patient with the VA
- Prescription from a referring physician is required
- Authorization outlining treatment visits allowed and the time frame allowed required prior to treatment.
- If this is not obtained you will be considered self-pay

If you are self-pay, service fees accrue on unpaid balances after 60 days.

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 with the above financial plan



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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:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Allergies                 | <input type="checkbox"/> Depression               | <input type="checkbox"/> Multiple Sclerosis   |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Diabetes Mellitus Type 1 | <input type="checkbox"/> Osteoporosis         |
| <input type="checkbox"/> Anxiety                   | <input type="checkbox"/> Diabetes Mellitus Type 2 | <input type="checkbox"/> Parkinson's          |
| <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Dizzy Spells             | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Emphysema/Bronchitis     | <input type="checkbox"/> Seizures             |
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Fractures                | <input type="checkbox"/> Strokes              |
| <input type="checkbox"/> Cardiac Conditions        | <input type="checkbox"/> Gallbladder Problems     | <input type="checkbox"/> Thyroid Disease      |
| <input type="checkbox"/> Cardiac Pacemaker         | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Cardiovascular Disease    | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Vision Problems      |
| <input type="checkbox"/> Chemical Dependency       | <input type="checkbox"/> Incontinence             | <input type="checkbox"/> Circulation Problems |
| <input type="checkbox"/> Kidney Problems           | <input type="checkbox"/> Currently Pregnant       | <input type="checkbox"/> Metal Implants       |
| <input type="checkbox"/> Headaches                 | <input type="checkbox"/> Nausea/Vomiting          | <input type="checkbox"/> Fevers/Chills/Sweats |
| <input type="checkbox"/> Muscular Weakness         | <input type="checkbox"/> Night Pain               | <input type="checkbox"/> Shortness of breath  |
| <input type="checkbox"/> 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? \_\_\_\_\_

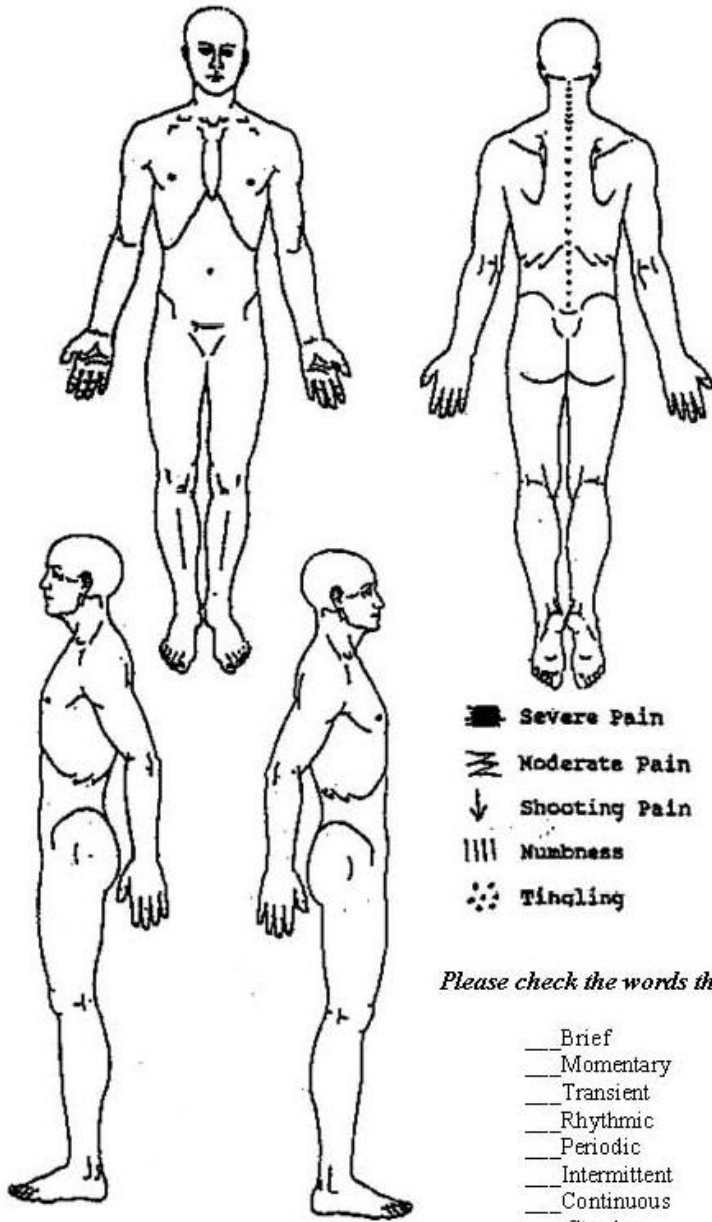
Types of caffeine used: Coffee \_\_\_ Soda \_\_\_ Tea \_\_\_ Chocolate \_\_\_

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?

*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