NORTHGATE
PHYSICAL THERAPY, P.C.

Name ____ Date of Birth (DOB) ________________
Last First MI

Address ____ Phone/Cell______________________

City ______________________ State ________ Zip ____________ Sex _________ Age__________

Parent/Guardian (if minor) ______________________________________DOB Parent ____________________

Responsible Party ____Phone ________________________

Emergency Contact Name & Phone # __________________________________ Relationship _____________

I grant permission for parent/spouse to receive information regarding my visits: YES / NO Initials______________

Referring Physician's office ______________________________ Referring MD __________________________

Have you ever been to Northgate Physical Therapy? _________ How did you hear about us? _____________________

Injury Date: ___________________ Type of claim (circle one): Private Insurance / Self Pay / Workers' Compensation

Private Insurance: Primary Insurance _______________________Policy# _________________ Group#__________

Primary Insured Name: ____________________________________ DOB _____________________

Tricare: Sponsor ID/SSN _____________________ Sponsor Name & DOB _______________________________

For Worker's Comp: Employer Name ____

Workers' Compensation Insurance _________________________________Claim#/SSN ____________________

I hereby grant permission to Northgate Physical Therapy, P.C. to perform such medical procedures they deem necessary. I authorize information and subsequent visits to be relayed verbally, written, or faxed to my family doctor, commercial insurance company, employer, and/or workers' compensation insurance carrier if applicable. I authorize Northgate Physical Therapy, P.C. to release any medical information necessary for the processing and payment of my bills to any insurance company or other third-party payer who is, or may be responsible, for paying for medical treatment. I further authorize release of copies to the referring physician or physicians consulted in regard to said treatment. I further authorize the use of said records for the purpose of workers' compensation disclosure. I hereby assign, transfer, and set over to Northgate Physical Therapy, P.C. all of my rights, title, and interest to my medical reimbursement under my insurance policy.

I understand that Northgate Physical Therapy, P.C. is NOT a participating provider for Medicaid. I certify that I am NOT a Medicaid recipient. I also understand that if I am a Medicaid recipient that I will not be able to file with Medicaid, or be reimbursed for my visit at Northgate Physical Therapy, P.C.

By my signature below, I authorize Northgate Physical Therapy, P.C. to treat me, and understand that all medical expenses shall be my responsibility. I understand I am responsible for obtaining information regarding my insurance benefits and payments coverage. Northgate Physical Therapy, P.C. is not responsible for obtaining this information.

____ Date ______________
Patient signature (Parent signature if patient is a minor)

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FINANCIAL POLICY

In-network Insurance
Please note that you are responsible for your copay, if applicable, at time of service. We will submit your insurance claims for you. **You may have a deductible to meet or a co-insurance percentage that will be billed to you.** Your costs will be determined upon the completion of claims processing according to your individual insurance plan. If coverage is denied for any reason, you will be responsible for the entire amount of your bill.

Out-of-network Insurance
If we are not an in-network provider for your insurance company, you may elect to pay cash.
<u>Cash-pay rates are as follows and payable at time of visit</u>:
$95.00 per visit
$85.00 for 5 visits = $425.00 (expires one year from purchase date)
$80.00 for 10 visits = $800.00 (expires one year from purchase date)
<u>Cash pay package rates are not transferable nor refundable.</u>

Workers' Compensation Patients
The employee is responsible to report a worker's compensation injury in writing within four (4) days.
The employer is responsible to fill out and mail a first report of injury to their insurance carrier within ten (10) days of injury notification. The insurance company is responsible to pay within 30 days of receiving the workers' compensation bill.
If the employer fails to file the first report of injury, the employee must file his/her own first report of injury. If the insurance carrier denies the claim for any reason, the patient will be responsible for the bill.

Dry Needling
Dry needling is not a covered service by commercial insurance companies. If you would like to receive this service, an additional $50.00 will be charged and paid for at time of service. If you are receiving physical therapy services at a cash pay rate, no additional fee will be incurred.

Cancellation/ Missed Appointment Fee
We request 24 hours notice prior to any cancellation or missed appointment. If 24 hours notice is not given, a $50.00 cancellation fee will be charged to the patient/guarantor.

Payment Guarantee
I hereby authorize the above insurance companies to pay any benefits for my care to Northgate Physical Therapy, P.C. directly. I have read this policy and understand that, regardless of any insurance coverage, including government agencies and third-party providers that I may have, I am responsible for payment of my account. In consideration of services to be provided, I agree to pay Northgate Physical Therapy, P.C. in accordance with the regular rates and terms of Northgate Physical Therapy, P.C. Returned checks are subject to a $50 service charge per check. Balances over 60 days will acquire an interest rate of 12% annum. I agree that in the event that my account is turned over to a collection agency or attorney due to non-payment, that I will pay up to an additional 50% of the balance as reasonable collection fees (to be added to the balance at the time the account is placed for collection) plus any court costs and attorney's fees incurred in connection with the collection of my account.

I understand my responsibility for payment of my account with Northgate Physical Therapy, P.C. and have provided, to the best of my ability, the information requested accurately and completely.

By signing below, I verify that I have read and agree to the above financial policy. I understand that I am responsible for payment of treatment of a minor if applicable. (A parent/guardian must sign if the patient is a minor/17 or younger).

Signature: ____ Date: _______________
(Patient signature or parent signature if patient is a minor)

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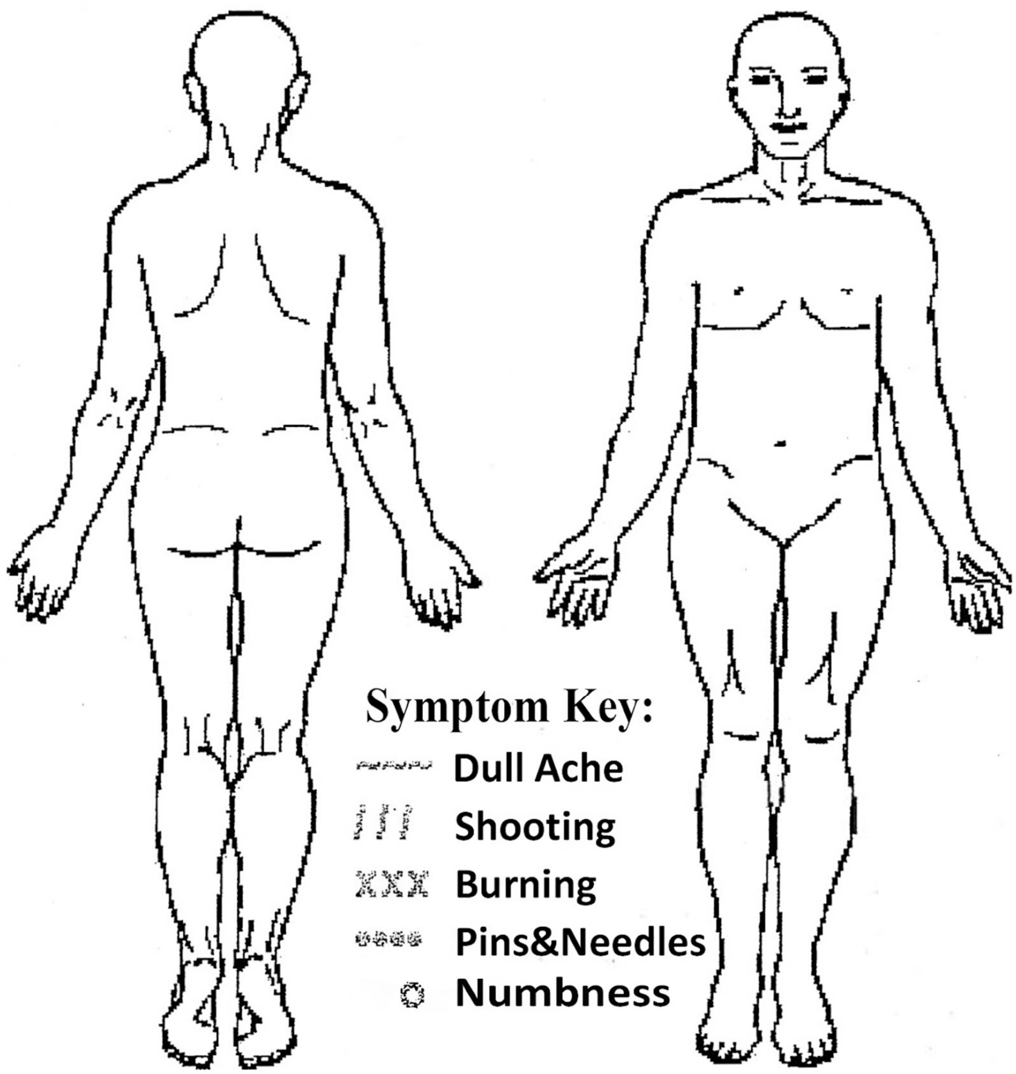
Pain Drawing

Please describe your current symptoms by marking on the drawing below, using symbols shown in the "Symptom Key", to indicate specific types of sensation:



The above chart is an accurate description of my current symptoms.

______________________________ ______/______/______

Claimant Signature **Date**

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

"You May Refuse To Sign This Acknowledgment"

I, ___________________________________, have received a copy of this office's Notice of Privacy Practices.

____
Print Name

____
Signature

____
Date

____
For Office Use Only
____

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

[ ] Individual refused to sign

[ ] Communication barriers prohibited obtaining the acknowledgement

[ ] An emergency situation prevented us from obtaining acknowledgement

[ ] Other (please specify)

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HIPAA Email Consent

- HIPAA stands for the *Health Insurance Portability and Accountability Act*
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information.
- Information stored on our computers is encrypted.
- Most popular email services do not utilize encrypted email.
- **When we send you an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.**
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA Act, the federal government provided guidance on email and HIPAA.
- The information is available in a PDF (page 5634) on the U.S. Department of Health and Human Services website: http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf
- The guidelines states that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.

ALLOW UNENCRYPTED EMAIL
I understand the risks of unencrypted email and do hereby give permission to Northgate Physical Therapy, P.C. to send me personal health information and general correspondence via unencrypted email.

________________________________ ________ ____________________________

Signature **Date** **Printed Name**
(parent or guardian if patient is a minor)

Please print email address: ____