NO SHOW/MISSED APPOINTMENT POLICY

We, at First Choice Physical Therapy, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the following number: **(775) 777-1276**

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder text is made/attempted to you one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24 hours' notice: There is a waiting list to see the clinicians at First Choice Physical Therapy and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.

2. If less than a 24-hour cancellation is given this will be documented as a "No-Show" appointment.

3. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.

4. After the first "No-Show/Missed" appointment, you will receive a phone call or letter of notification that you have broken our "No-Show" policy. First Choice Physical Therapy will assist you to reschedule this appointment if needed.

5. If you have 2 "No-Show/Missed" appointments within one-year, you will be assessed a **$25.00** no-show fee.

6. If you have 3 "No-Show/Missed" appointments within one-year, you will receive a second **$25.00** no-show fee assessment. Dismissal from the practice will be considered.
    a. ***You will be notified by letter if the dismissal was approved.**

*****We are committed to your success by providing you with the best care possible. Part of our exceptional care is YOUR active participation in your doctor ordered therapy program. You will SLOW your progress and potentially LIMIT your outcomes when your recommended therapy program is not followed.**

I have read and understand First Choice Physical Therapy's No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify First Choice Physical Therapy appropriately if I have difficulty keeping my scheduled appointments.

____________________________ ____________ ____________

Patient Name | Date of Birth | Date

____________________________ ________________

Patient Signature or Parent/Guardian if minor | Relationship to Patient

____________________________ ________________

Staff Signature | Date

COVID-19 Questions

Please review the questions below, if you answer YES to any of these questions, please contact our office at (775) 777-1276 for further guidance. Thank you.

1. Have you or anyone in your household had a fever in the last (3) days, respiratory symptoms (cough and shortness of breath), Flu like symptoms or have been in contact with anyone with a confirmed test of COVID-19?
2. Other than healthcare professionals working in patient care, are you currently providing care for anyone who has been diagnosed with COVID-19, had a fever, cough, difficulty breathing or flu-like symptoms in the last 2 weeks?
3. Do you have any of these symptoms?
4. Fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headaches, new loss of taste or smell, sore throat, congestion, or runny nose, nausea, vomiting or diarrhea?
5. Have you had a positive COVID-19 test for active virus in the past 10 days, or are you awaiting results of COVID-19 test?

I acknowledge that I have not had close contact with someone who has had COVID-19 or have exhibited symptom of COVID-19.

____
(Sign here)

Thank you

First Choice Physical Therapy

FIRST CHOICE PHYSICAL THERAPY
REGISTRATION FORM

Important Please fill out completely

Today's date: PCP:

PATIENT INFORMATION

Patient's Last name: First: Middle: ❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms. **Marital status** (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No | If not, what is your legal name? | (Former name): | **Birth date:** / / | Age: | **Sex:** ❑ M ❑ F

Street address: | Social Security no.: | **Home phone no.:** ( )

Email: | **Cell Phone no.:** ( )

P.O. box: | City: | State: | ZIP Code:

Occupation: | Employer: | Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Billboard ❑ Other

Other family members seen here: | **Is this work related?** ❑ Yes ❑ No | Injury Date:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize First Choice Physical therapy or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Today's Date:____________________

Name:________________________________Date of Birth :______________Occupation:___________

Please describe what happened to initiate your condition: ____________________________________

____

Is this work related? Yes / No If yes, what is the Date of Injury? ______________________________

Is this accident related: Yes / No If yes, how and when and where did it happen?_______________
____Date of Injury:_________________________

Have you had any surgery for this condition? Yes / No Date of Surgery: ________________________

Have any recent diagnostic test been performed (MRI, X-ray, etc): _____________________________

What daily activities (including work) do you have difficulty with as a result of this condition? ________

____

Have you received any treatment (physical therapy, Chiropractic, MD, etc) for this condition? ________

____

What activities/positions aggravate your symptoms? ____

What activities/positions relieve your symptoms? ____

Do you have the following conditions?

___Diabetes
___Pacemaker
___Allergies
___Nervous Disorders
___Metal Implants
___Hernia
___Chest Pain

___High Blood Pressure
___Headaches
___Dizziness
___Dermatitis
___Previous Surgeries
___Lung Disease

___Heart Attack
___Kidney Problems
___Cancer
___Numbness
___Seizures
___Arthritis

Current Medications: ____

____

Do you currently Smoke? Yes / No Number of packs a day ______________________________

Patient Signature: ____________________________

FIRST CHOICE PHYSICAL THERAPY
SPRING CREEK, ELKO, CARLIN
(775) 777-1276

First Choice Physical Therapy
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

First Choice PT. is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment---We *may* disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment, or healthcare operations. (example)

> *"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with First Choice P.T."*

> *"It is our policy to provide a substitute health care provider, authorized by First Choice P.T. to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."*

Payment---We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

> *"As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to First Choice P.T for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."*

Workers' Compensation---We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies---We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health---As required by law, we may disclose your health information to public health authorities for purposes related to preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings---We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement---We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Public Safety---It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies---We *may* disclose your health information for military, national security, prisoner, and government benefits purposes.

Marketing---We may contact you for marketing purposes or as described below: (example)

> *"As a courtesy to our patients, it is our policy to contact you on the evening prior to your scheduled appointment* to *remind you of your appointment time. If contact is by phone, and you are not at home, we will leave a reminder message on your*

answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."

Change of Ownership---In the event that First Choice P.T. is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that First Choice PT. is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that First Choice P.T. amend your protected health information, please be advised, however, that First Choice P.T. is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by First Choice PT.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices---First Choice P.T. reserves the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all information that it maintains. Until such amendment is made, First Choice P.T. is required by law to comply with this Notice.

First Choice P.T. is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Sam Moore by calling this office at *775-777-1276*. If he is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints---Complaints about your Privacy rights or how First Choice Physical Therapy has handled your health information should be directed to Sam Moore by calling this office at 775-777-1276. if he is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of ____/____/____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide First Choice Physical Therapy with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

____
Patient's Name (print)

________________________________ __________
Patient's Signature Date

________________________________ __________
Authorized Facility Signature Date

First Choice Physical Therapy
Spring Creek - 248 Country Club Parkway, Spring Creek, NV 89815
Carlin – 617 Main St. Carlin, NV 89822
Elko – 2219 5th Street Elko, NV 89801
Telephone: (775) 777-1276 Fax: (775) 777-7022

PAYMENT POLICY FORM

______**PRIMARY INSURANCE**---We will bill your primary insurance as a courtesy to you. We will assume payment of **insurance** benefits is **not forthcoming on charges older than** 60 days. **Charges outstanding for more than 60 days will be due in full from you regardless of the type of insurance involved.** Any remaining balance after your co-pay and your primary coverage has been paid, including items classified as "above usual and customary," is due from you upon receipt of the explanation of benefits from your primary insurance carrier. You will be responsible for any item not paid in full by your insurance carrier. Prior to beginning treatment, we will verify your insurances benefits. While we will take all reasonable action to provide accurate therapy benefit information for your specific plan, be aware that verification of benefits is not a guarantee of payment from your insurance carrier.

______**MEDICARE**---We will bill Medicare for you. In most cases, Medicare will pay 80% of allowable charges. We will bill your secondary insurance for you, if you have one, or the balance will be billed to you.

______**MEDICAID**---We will bill Medicaid for you. After your initial eval, we will need to get prior authorization from Medicaid before we schedule follow-up appointments. This process can take a few days. Any unpaid balances by Medicaid will be billed to you.

______**SELF PAY---Please pay the balance in full at the time of service.** When paying at the time of service, **Initial Evals will be $100.00, and Follow-up visits will be $90.00.** In the event that you are unable to pay the balance in full, we are willing to make reasonable payment arrangements with you. Please be advised that First Choice Physical Therapy is not a credit grantor, and therefore, failure to maintain these arrangements will result in the placement of your account with a collection agency or attorney for collection. Credit cards are accepted for payment on account.

______**WORKERS' COMP**---We will bill you Workers' Comp carrier for your charges. Please note that you will remain financially responsible for all of your charges if your carrier denies coverage.

______**LEGAL SUIT**---We will accept a legal letter of protection if you meet each of the following criteria:

1. Do not qualify for benefits under any insurance policy (medical or auto), and

2. Are indigent and cannot pay for charges due using cash or credit card, and

3. Are awaiting settlement and subsequent payment of damages from a related legal case, and

FIRST CHOICE PHYSICAL THERAPY

4. Return our lien, signed by both you and your attorney.

Prior to your settlement, payment on your account will not be required unless your charges remain outstanding for more than 60 days from the date of the last treatment. Upon settlement of your legal case, your balance is due in full within 30 days. Please be aware that you will remain financially responsible for services rendered regardless of the payment option selected above. In the event your account becomes delinquent and is therefore in default of payment, the patient, legal guardian, or admitting parent will be responsible for the principal amount owing, and all reasonable costs associated with the collection of debt, including, but not limited to, collection service fees, attorney's fees, and all court costs and additional legal expenses associated with the recovery of this debt. We reserve the right to charge interest **at a rate of 1.5% (12% annually)** on balances over 30 days old, charge returned check fees as allowed by state law, and charge a no-show fee for missed appointments when adequate notice of cancellation is not provided. Thank you for allowing us the opportunity to serve you. If you have any questions about the above information or any uncertainty regarding your insurance coverage, please ask for our assistance. Kindly sign and date this document to indicate that you understand and agree to the terms of this payment policy.

CONSENT FOR TREATMENT OF A MINOR: As parent and/or legal guardian, I authorize *First Choice Physical Therapy* to treat the minor patient named in the attached consent form while I am not present.

CANCELLATION/NO-SHOW POLICY: To maintain appointment times available for all of our patients, there is a charge of **$25.00, *BILLED TO THE PATIENT,*** for each instance a patient does not show for a scheduled appointment or does not give at least 24-hour cancellation notice. Patients who incur two **NO SHOW/NO CALL** incidents will be discharged from physical therapy services. We also reserve the right to cancel **DELINQUENT TARDINESS**, for which we will also apply this policy.

☐ Checking this box indicates that the formal office **HIPAA policy and procedures** have been explained to the above-noted patient and that a copy of the policy was provided to the patient.

Assignment of benefits/authorization to release medical information/consent to treatment: I hereby assign all medical benefits to which I am entitled to First Choice Physical Therapy, in the event they file insurance on my behalf, I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is there in default of payment I accept responsibility for the principal amount owing as well as reasonable costs associated with the collection of this debt. Interest may be charged at a rate of 1.5% per month (12% annually) for unpaid balances over 30 days old. This includes but is not limited to collection service fee, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original.

I do hereby consent to such treatment by the authorized personnel of First Choice Physical Therapy as

maybe dictated by prudent medical practices by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

______________________________ ______________________

AUTHORIZED SIGNATURE DATE