INFORMED CONSENT & GUIDELINES

ENDURANCE PHYSIO

PATIENT NAME: ______________________________

PATIENT GUIDELINES

Thank you for selecting Endurance Physio for your physical therapy needs. Please understand that for your treatment benefit to be maximized, you must regularly attend your therapy appointments and perform your home exercises and/or instructions. You should notice a direct relationship between your commitment and your improvement!

Please understand that you are responsible for scheduling and keeping appointments. All our time is valuable, and in an effort to respect your time and that of our therapists and other patients, we require a ONE BUSINESS DAY notice to change or cancel your appointment. We understand we all have busy lives and things come up last minute, however, late cancellations and no shows are subject to a $50 cancellation fee.

Endurance Physio will be responsible for billing your insurance company and you will receive a statement accordingly. Although we make an effort to understand all our patient's physical therapy benefits, ultimately it is your responsibility and you are responsible for charges that are not reimbursed by your insurance.

RELEASE OF INFORMATION AUTHORIZATION

I authorize my referring provider to release my medical records to Endurance Physio for their file relating to my physical therapy diagnosis. Endurance Physio may request such information as my medical chart, provider notes, radiology and/or operative reports.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been shown a printed copy of the Notice of Privacy Practices and consent to the provisions of this notice. I understand that a copy of this Notice is available for download on the Endurance Physio website (endurancephysio.net) should I want my own copy.

INFORMED CONSENT

I acknowledge that I have been informed that physical therapy involves participation in activities to increase strength, balance, etc. via exercise and modalities which carry a risk of exacerbation of symptoms or other injury. I am signing this form with full knowledge of the associated risks.

This consent form will remain in effect until renounced. A photocopy of this document is considered as valid as this original. We appreciate your cooperation throughout your therapy with us. We are excited to work with you towards your treatment goals.

Signature: ______________________________ Date: ________________

(Patient, Parent, or Legal Guardian)

If signed by a patient representative, indicate relationship to patient: ________________

AGREEMENT OF FINANCIAL RESPONSIBILITY

ENDURANCE PHYSIO

PATIENT NAME: ____

Thank you for choosing us as your healthcare provider. We are committed to providing quality care and service to all our patients. The medical services you seek imply a financial responsibility on your part. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment. Feel free to ask if you have any questions regarding your financial responsibility.

- Please understand the payment of your bill is considered part of your treatment. We accept cash, check, credit/debit cards, and pre-approved insurance.
- Providing your insurance information does not guarantee coverage is effective or that the services rendered will be covered by your insurance company.
- It is your responsibility to know your own insurance policy, eligibility, and benefits, including:
  - Whether we are In-Network or Out-of-Network with your insurance company
  - Exclusions in your policy
  - Referral requirements of your insurance plan
  - Pre-authorization/precertification requirements of your insurance plan
  - Deductibles, co-insurance, and copayment amounts
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information. Denied claims are subject to a minimum patient responsibility of $200 if unable to resolve.
- If we are contracted with your insurance company we will bill your insurance company. You are responsible for deductibles, co-payments, co-insurance amounts and/or any other patient responsibility indicated by your insurance carrier or our policies.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, copayments, and benefits that differ greatly from In-Network benefits. If you receive services that are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

CARD ON FILE POLICY

We require a card on file for all patients who have a copay or elect to pay Fee at Time of Service ($150). To reduce medical billing and back-end collection costs, the card on file will be charged for copays and Fees at Time of Service at check-in.

PAYMENT PLANS

Payment plans can be set up upon request. Please let front desk staff or your therapist know if you think you might need to set up a payment plan.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature: ____ Date: ________________________

(Patient, Parent, or Legal Guardian)

If signed by a patient representative, indicate relationship to patient: ____________________________

MEDICAL INFORMATION

ENDURANCE PHYSIO

NAME: ______________________ DATE: ______________

Are you currently working? Y N If so, how many hours per week? __________

Occupation: ______________________

Are you right or left hand dominant? Right Left

Do you use tobacco products? Y N If yes, amount per day? __________

Are you pregnant? Y N

CHECK ALL THAT APPLY:

- [ ] Allergies
- [ ] Asthma, difficulty breathing
- [ ] Broken bones
- [ ] Depression
- [ ] Diabetes, hypo/hyperglycemia
- [ ] Dizziness or vertigo
- [ ] Fainting, seizures
- [ ] Headaches
- [ ] Heart condition or pacemaker
- [ ] High/low blood pressure
- [ ] Injury to head, chest, organs
- [ ] Lung disorder
- [ ] Mental condition
- [ ] Night pain
- [ ] Osteoporosis
- [ ] Osteoarthritis
- [ ] Severe illness
- [ ] Stroke
- [ ] Swelling, joint pain
- [ ] Vision or hearing problems
- [ ] Cancer
- [ ] Rheumatoid Arthritis
- [ ] Autoimmune disorder
- [ ] Significant weight loss/gain

OTHER RELEVANT MEDICAL HISTORY OR ISSUES:

____

____

SURGERY HISTORY:

Procedure: ______________________ Date: ______________

Procedure: ______________________ Date: ______________

Procedure: ______________________ Date: ______________

Have you experienced any of the following in the last three months? (check all that apply)

- [ ] Subtle onset of pain
- [ ] Fatigue
- [ ] Chest pain
- [ ] Fever
- [ ] Weight loss
- [ ] Change in appetite
- [ ] Night pain

CURRENT CONDITION

ENDURANCE PHYSIO

What are we seeing you for today? ______________________________

Is the issue from a recent injury or is it chronic? ______________________________

When did it happen/start? ______________________________

How did it happen? ______________________________

What makes it better? ______________________________

What makes it worse? ______________________________

Have you had medical testing such as x-rays, MRIs, etc? *(circle one)* YES NO

Have you tried physical therapy for this issue before? *(circle one)* YES NO

On a scale of 1 - 10 (1 being no pain, 10 being the worst pain), how do you feel:

Right now: ________ At your worst: ________ At your best: ________

How much does your pain affect your ability to do the activities you want to do? *(mark one)*

☐ Not at all. ☐ A little bit. ☐ A lot. ☐ Activities are impossible.

What was your pre-injury activity level:

____

____

What is your current activity level and do you experience pain during or after these activities?

____

____

What are your goals for physical therapy?

____

____

Use the figures (right) to indicate your pain symptoms:

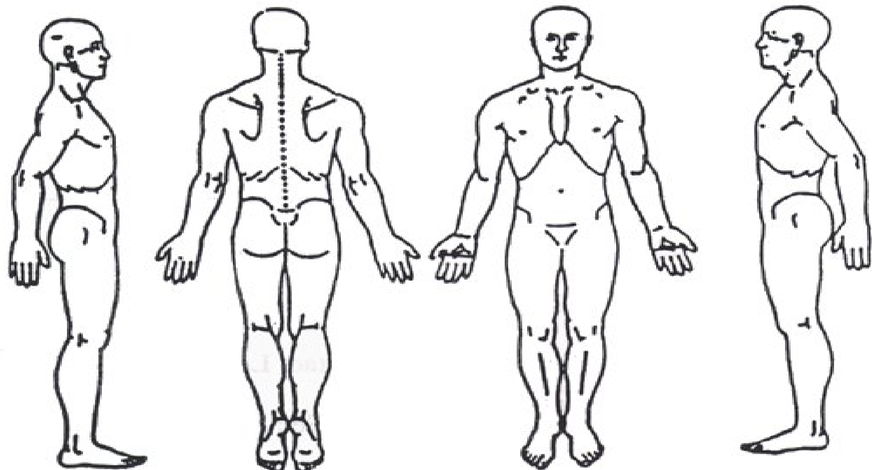
A = Ache

S = Stabbing

R = Radiating

P = Pins & Needles

O = Other



MEDICATION LIST

ENDURANCE PHYSIO

NAME: ______________________ DATE: ______________

MEDICATION	DOSE	FREQUENCY