Dutch PhysicalTherapy New Patient Information 2023

First Name: _____ **Middle Initial**: _____ **Last Name**: _____

Home Phone: _____ **Cell**: _____**Work:** _____

What is the best number to reach you at to confirm appointments? Home | Cell | Work

Birth Date: _____ /_____ / _____ **Sex**: M / F **Social Security No**.: _____ -_____ - _____

Street Address: _____**City**: _____**State**: _____ **Zip**: _____

Email address: _____ (would you like to be added to our email list? Yes / No)

Marital Status: single married divorced widowed other **Employment status**: full time part time student retired other

Employer: _____ **Employer Phone**: _____

If Married, Spouse's Name, Employer & Phone number_____

Responsible Party Information: Patient's Relationship to responsible Party: Self | Spouse | Child | Other

Name: First_____MI_____Last_____ Home Phone No.: _____

Address: _____ City, State, Zip Code: _____

Employer: _____ Employer Phone: _____

Emergency Contact Information:

Person/Relationship: _____ Phone Number: _____ **How**

did you hear about us? Check all that apply:

Doctor | Friend/Family | Billboard | Postcard | Newsletter | Email | Seminar | Website | Ins Network | Other: _____

Whom may we thank for referring you?_____

Referring Physician: _____ Primary Physician: _____

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Injury/Accident Related? Yes / No Date of Accident: _____ Do you have an Attorney? Yes / No

If Yes, Please give Attorney Name and Phone No.: _____

If an accident, is this a Work related injury or Motor Vehicle Accident? (Yes or No) If yes, what is your claim no.?_____

Please give the name of the at fault parties Insurance Carrier/Workers Comp. Payer: _____

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Has the patient received any type of physical/occupational therapy and/or home health services within the current calendar year? (For this injury or any other injury) YES / NO

If yes, explain:_____

Have you been discharged or are you currently treating? _____ If yes, Please give name and phone no. of the Home Health Agency: _____

If yes, Please give the name of the clinic or facility: _____ How many visits were received? _____

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Authorization and Assignment

I authorize Dutch Physical Therapy, Inc. to release medical information that may be necessary to request claim reimbursement from insurance companies or other payors to whom claims may be submitted. I also assign claim payments including major medical benefits to be made payable to Dutch Physical Therapy, Inc. I understand that Dutch Physical Therapy, Inc. will refund to me any overpayment upon request, regardless of insurance. This authorization and assignment may be revoked by me at any time by a written notice.

Acknowledgment of Receipts of Notice of Privacy Practices

My signature below indicates that I have been given the Notice of Privacy Practices for Dutch Physical Therapy. I recognize that outside of purpose for my evaluation, treatment, for payment, for certain healthcare operations or as permitted or required by law, I must give my written authorization to Dutch Physical Therapy, to release any of my protected healthcare information.

Patient Name (Print): _____ Date: _____

Patient or Legal Guardian Signature: _____ Date: _____

DUTCH PT Physical Therapy

Pain Diagram | 2023

Name: _____

Pain Levels:

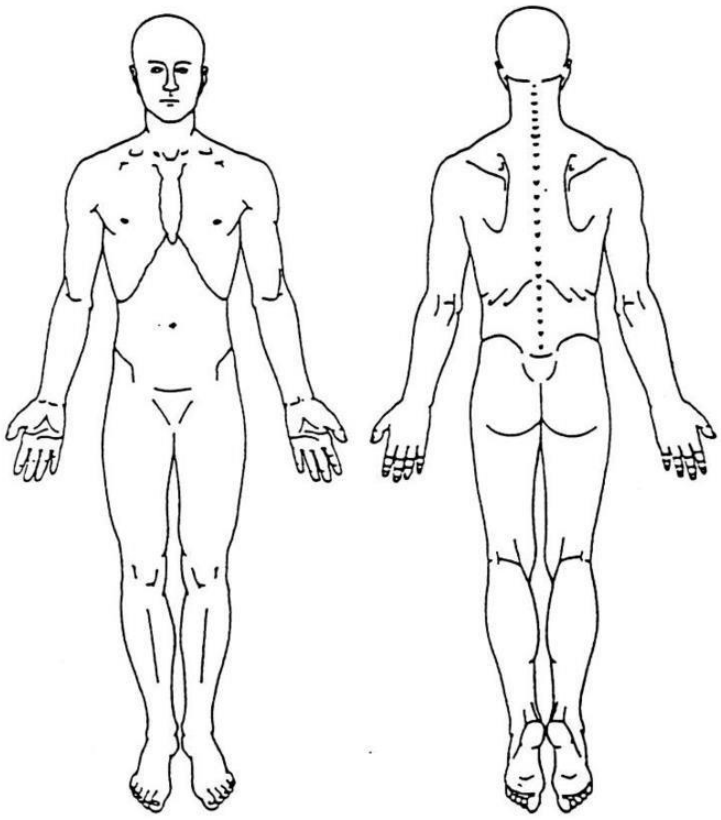
Current: _____ Best: _____ Worst: _____

No Pain					**Moderate Pain**						**Unbearable**
0	1	2	3	4	5	6	7	8	9	10	☹

Indicate the Location of your pain:

Key:

0000 Pins and Needles
XXXX Burning
||||| Stabbing
+++++ Aching
____ Other



Dutch PhysicalTherapyMedication List 2023

Due to recent changes in Medicare policies we are required to collect the following information in addition to completing a functional index survey every 10th visit.

First Name:_____ **Middle Initial**:_____ **Last Name**:_____

Height: _____**Weight:** _____

List Medications Currently Taking:

Prescription or OTC Drug	Frequency Taken	Dosage
Ex: Celebrex	**twice daily**	**10mg**

Authorization and Assignment

I authorize Dutch Physical Therapy, Inc. to release medical information that may be necessary to request claim reimbursement from insurance companies or other payors to whom claims may be submitted. I acknowledge that this information is true and correct to the best of my knowledge.

Patient Name (Print): _____ **Date:** _____

Patient or Legal Guardian Signature: _____ **Date:** _____

Dutch Physical Therapy
Informed Consent for Physical Therapy 2023

PLEASE READ CAREFULLY

I, _____, do hereby give my voluntary consent for the administration of Physical Therapy deemed appropriate by my treating Physical Therapist and their supporting team of Physical Therapy Assistants under the rules & recommendations of the Louisiana Board of Physical Therapy Board.

I understand that the purpose of Physical Therapy is to treat disease, injury and disability by examination, evaluation, palpation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization(s), manual therapy, massage, exercises, manual & verbal cueing, education and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you asked to perform them. Initial: _____

I understand that the primary goals of my physical therapy treatments are to help reduce my pain and to improve my posture, body mechanics, mobility, strength, stability, endurance, function & quality of life.

Initial: _____

I understand that there are very small possibilities of risks or complications that may result from the above listed treatments. I do not expect the Physical Therapist and/or Physical Therapist Assistant to anticipate all the possible risks and complications. I wish to rely on the Physical Therapist and/or Physical Therapist Assistant to exercise proper judgment during treatment to make decisions based upon my best interest.
Initial: _____

Potential possible risk factors:

I acknowledge that physical therapy services and/or treatments, to a greater or lesser degree, may result in weakness, paralysis, pain, numbness and/or limitations of movements and being mindful of such risks agree and consent to all procedures and medical services and/or treatments deemed necessary by Dutch Physical Therapy and the patient's Physical Therapist and/or Physical Therapist Assistant. I acknowledge that all information provided is made in the best professional judgement of Dutch Physical Therapy and being mindful of the uncertain nature of complications that there is no guarantee, expressed or implied, as to the success or other results of the physical therapy services and/or treatments rendered.

Manual Therapy: A hands-on approach which could potentially cause joint and/or muscle soreness

Exercise Therapy: On occasional hands-on approach, in an individual as well as gym setting, which could potentially cause soreness and/or discomfort, usual potential risk of performing exercises with or without use of gym – and cardiovascular equipment, fall risk with balance and stability exercises

Electrical Therapy: Minor skin irritations such as redness or rash. The patient can request individual electrodes and will be charged a small supply fee

Therapeutic Taping: In case of allergies to the tape, skin irritations such redness or rash might occur, Dutch Physical Therapy recommends removing tape within 6-8 hours of application

Dry Needling: Minor soreness, bleeding, bruising, nausea, fainting, infection, shock convulsions, possible perforation of internal organs, stuck or bend needles, and fetal distress in pregnant women

Mechanical Traction: Soreness, bruising, nausea, dizziness, fainting and Dutch Physical Therapy would like to stress the following contraindications of performing traction with patients diagnosed with Acute Cervical Injury, Osteomyelitis, Spinal Instability, Spinal Hypermobility (during pregnancy), Tumors, Rheumatic Arthritis and when suffering of any Vascular Diseases of the head & neck

Heat and/or ice modalities: Minor skin irritations, in extreme cases burns Initial: _____

I understand and acknowledge that my Physical Therapist may have to **touch, contact, and manipulate my body (sometimes in places that are customarily kept covered by clothing)** while performing treatment(s) and techniques. **I hereby consent** to such touching, contact and manipulation.
Initial: _____

I understand it is **my right to decline any part of a treatment at any time** before or during treatment for any reason including, feeling personally uncomfortable with any touching, treatment or technique; feeling any discomfort or increased pain; or, having unresolved concerns. Initial: _____

I understand that I am entitled to a chaperone present at my physical therapy sessions and I understand that if I would like someone in our individual treatment room, I will inform my Physical Therapist or Physical Therapist Assistant to arrange. Initial: _____

I understand that it is my right to ask your Physical Therapist and Physical Therapy Assistant about the treatment planned based on your individual history, diagnosis, symptoms and examination results. Consequently, it is my right to discuss the potential risks and benefits involved in my treatment.
Initial: _____

I will notify my Physical Therapist of any medical conditions and I will immediately notify my Physical Therapist of any changes in my medical status, medications or pregnancy. Initial: _____

I accept the fact that there is no guarantee of the effectiveness of the treatment. Initial: _____

I have read this consent form and understand the risks involved in my physical therapy treatment and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care as well as recommended home exercise program. Initial: _____

I understand it is my responsibility to wear appropriate comfortable clothing such as you would wear to the park or gym, if not; Dutch Physical Therapy has the right to deny treatment. Initial: _____

I acknowledge that I have received a notice of privacy practice which is available upon request at all our locations. Initial: _____

I understand that Dutch Physical Therapy recommends any minor patient to be accompanied by a parent/guardian. If the parent/guardian chooses not to have their minor accompanied during her/his examination or treatment, a written consent needs to be signed by the legal parent/guardian.

Initial: _____

I HAVE CAREFULLY READ AND UNDERSTOOD THE FOREGOING.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

FINANCIAL RESPONSIBILITY – CANCELLATIONS – CONSENT FOR TREATMENT MEDICAL RELEASE AND ASSIGNMENT OF INSURANCE BENEFITS

PATIENT NAME: _____ **DATE:** _____

FINANCIAL RESPONSIBILITY

I/We certify that the information provided to Dutch Physical Therapy is true and correct to the best of my knowledge and belief. In consideration of the physical therapy services and/or treatments rendered to the above named patient, I/We assume responsibility for and guarantee the payment of all service and/or treatment charges in accordance with the practice's then current rates. The patient portion of all charges is due and owing at the time services and/or treatments are rendered. The legal judicial interest rate will be added to all unpaid balances which are more than thirty (30) days delinquent. I/We also agree that, except as provided by law, I/We shall be responsible for the payment of any service and/or treatment charges which for any reason are not paid by any payor or insurance company. I also authorize Dutch Physical Therapy to initiate a complaint to the Insurance Commissioner in my name and to deposit checks made in my name. In the event this account is rendered delinquent and is placed in the hands of an attorney for collection and/or resolution of account disputes, regardless whether formal legal action is instituted, I/We agree to pay, in addition to the principal amount due and owing, a fee of fifty (50%) percent of the principal amount as well as all costs incurred in connection with said collection. I/We acknowledge that in addition to the face amount of the check, additional fines, fees and penalties will apply to all NSF and/or stop-payment checks as provided by law, including but not limited to a **twenty-five ($25.00) dollars NSF service charge** and/or fifteen ($25.00) dollars stop-payment service charge, and agree to pay such prior to the rendering of further physical therapy services and/or treatments. **NOTICE TO PATIENTS PAYING BY CREDIT CARD - I/We authorize Dutch Physical Therapy to charge against said credit card all unpaid balances which are more than ninety (90) days delinquent, which preauthorization will remain in effect until I/We deliver to Dutch Physical Therapy written notification of revocation in such time and manner as to afford Dutch Physical Therapy the reasonable opportunity to act upon said revocation.** I/we understand that Dutch Physical Therapy will refund me any overpayment upon request.

CONSENT FOR TREATMENT

I/We acknowledge that physical therapy services and/or treatments, to a greater or lesser degree, may result in weakness, paralysis, pain, numbness and/or limitation of movement and being mindful of such risks agree and consent to all procedures and medical services and/or treatments deemed necessary by Dutch Physical Therapy and/or the patient's physical/occupational therapist. I/We acknowledge that all information provided is made in the best professional judgment of Dutch Physical Therapy and being mindful of the uncertain nature of complications that there is no guarantee, expressed or implied, as to the success or other results of the physical therapy services and/or treatments rendered. I/We have read, and consent to, the Dutch Physical Therapy Informed Consent form.

MEDICAL RELEASE AND ASSIGMENT OF INSURANCE BENEFITS

I/We authorize Dutch Physical Therapy to release all medical records, billing information and/or other protected health information, which may be of a sensitive nature to the Social Security Administration, health maintenance organizations, worker's compensation carriers, employers, or persons acting on behalf of a preferred provider arrangement (or any of their agents or representatives), when such information is requested for payment, utilization review or coverage determination purposes. I/We understand that this authorization is strictly voluntary, that I/We may refuse to consent to such and may revoke such consent at any time, except in instances where a particular action depends upon the consent remaining in effect, including but not limited to securing full payment of the account(s). This authorization shall remain in effect for the greater of a period of not more than two (2) years from the above indicated date or until payment of this account is rendered in full. The authorization to release medical information herein contained shall also apply to all physical/occupational therapists employed by and/or contracted through Dutch Physical Therapy. I/We further authorize any such payor or insurance company to pay directly to Dutch Physical Therapy all benefits due and payable as a result of physical therapy services and/or treatments rendered by Dutch Physical Therapy. I/We hereby assign to any physical therapist providing manual and physical therapy or other services rendered in connection with this treatment, all benefits due me for such services and/or treatments under any applicable policy of insurance. I/We accept the financial responsibility to Dutch Physical Therapy and/or said physical therapist for all charges for services and/or treatments not paid by any payor or insurance company and hereby promise to pay within thirty (30) days of the date of service and/or treatment any remaining balance.

_____ _____

SIGNATURE OF PATIENT OR PATIENT'S LEGAL GUARDIAN **DATE**

_____ _____

RELATIONSHIP TO PATIENT **SIGNATURE OF WITNESS**

Consent to Treat Minor

By signing below, I hereby give my consent to Dutch Physical Therapy to evaluate and treat the following minor child:

Child's Name: _____

Child's Date of Birth: _____

Relationship to Child: _____

Please note: Dutch Physical Therapy strongly encourages parent or legal guardian participating in the evaluation and treatment. In the initial evaluation & treatment and during to follow up visits, the PT will establish the plan of care and review in detail the necessary treatment components of the plan of care, including the frequency and duration of visits. It's important for both the parent and the patient's parent(s)/guardian(s) to understand the treatment being provided and to provide informed consent to the specified treatment plan.

Please carefully review Dutch Physical Therapy's Informed Consent document. The provisions of that document apply to the treatment of the minor child.

I understand the above noted description of the physical therapy evaluation and treatments and recognize the importance of attending this appointment with my minor child. If I am unable to attend, I will accept responsibility to contact the evaluating physical therapist directly with any questions or concerns related to the evaluation or specified treatment.

I, _____, the parent or legal guardian, allow the following people to accompany my child to his/her physical therapy visits:

1) _____ Relationship: _____

2) _____ Relationship: _____

3) _____ Relationship: _____

A valid ID will be required to accompany your child.

Printed name of parent or legal guardian: _____

Signature of parent or legal guardian: _____

Date: _____ Phone

number: of parent or legal guardian: _____

Email address of parent or legal guardian: _____

SUPPLIES WAIVER & NON-COVERED ITEMS

Because many insurance companies do not cover certain items, there may be some supplies which your therapist will use and/or recommend, which are not covered by insurance reimbursement. For example, if electrical stimulation is used in your treatment plan, a new, unopened, re-usable set of electrode pads will be needed. Upon receipt, you the patient will be responsible for paying the one-time charge per item for these pads. Examples of some other items which are recommended are; TheraBand Exercise Bands, braces, neck and back supports and educational books, home traction units, shoulder pulley, TENS unit, balls, etc. If any of these items are required, you will be notified prior to use so that you are aware of any potential out-of-pocket expenses you might be responsible for.

Patient Name: _____

Account # _____

Date of Purchase: _____

Supplies Purchase: _____

_____

_____

By signing below, you are made aware that you are **not required to purchase** the recommended products. This is simply an acknowledgment that your insurance will not cover certain supplies. Also, this is an advanced notice that Dutch Physical Therapy is not a DME supplier for your insurance. Therefore, a claim for the above listed supplies will not be billable to your insurance and you (the patient) are responsible at 100%. If you (the patient) elect to **purchase supplies** all sales are final and there will be no returns.

_____ _____

Patient Print Name Date

_____

Patient Signature

_____ _____

Patient Service Representative Date

Dutch Physical Therapy 2023 Cancellation Policy

To Our Patients Regarding

CANCELLATION AND NO SHOWS

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic, because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist has prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your goals in treatment.

- **WE REQUIRE 24 HOURS NOTICE IN THE EVENT OF A CANCELLATION**. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible. (In some cases, this may not work since some forms of treatment do not work well if given two sequential days.)

- You may need to see a therapist other than the one who normally treats you if you do re-arrange your appointment. All of our therapists are experienced professionals, and they will study your patient chart, so you will be in good hands. You will return to your original therapist on the next regularly scheduled visit.

- **THERE IS A $25.00 CHARGE FOR A CANCELLATION WITHOUT PROPER NOTICE. THIS CHARGE WILL NOT BE COVERED BY INSURANCE, BUT WILL HAVE TO BE PAID BY YOU PERSONALLY.**

- For Worker's Compensation and Personal Injury patient's documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.

- Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. Either of the following conditions may seem to be a reason not to come in: (A) YOU ARE FEELING WORSE AND THINK THE TREATMENT IS NOT WORKING; or (B) YOU ARE FEELING BETTER AND IT IS A GREAT DAY FOR WINDSURFING. However, neither of these conditions is really a legitimate reason not to come to treatment because: (A) IF YOU ARE IN PAIN, COME IN AND GET FIXED; and, (B) IF YOU ARE NOT IN PAIN, NOW IS THE TIME THAT WE CAN BEGIN DOING SOME REAL CORRECTION OF THE UNDERLYING CAUSES OF YOUR PROBLEM AND EDUCATE YOU SO YOU WILL NOT RE-INJURE YOURSELF, ETC.

- When you do not show as scheduled, three people are hurt: (1) YOU- BECAUSE YOU DO NOT GET THE TREATMENT YOU NEED AS PRESCRIBED BY THE DOCTOR AND/OR PT; (2) YOUR THERAPIST- WHO NOW HAS A N UNUSED SPACE IN THEIR SCHEDULE SINCE THE TIME WAS RESERVED FOR YOU PERSONALLY; and, (3) ANOTHER PATIENT- WHO COULD HAVE BEEN SCEDULED FOR TREATMENT IF YOU HAD GIVEN PROPER NOTICE.

Please cooperate with us in this regard. We are looking forward to working with you.

_____ _____

PATIENT'S SIGNATURE DATE

_____ _____

PSR SIGNATURE DATE