Core Physical Therapy & Sports Performance
1340 Elm Street St. 101, Morgan City, LA 70380
Phone 985-384-1999 **Fax** 985-384-1998
www.CorePTLA.com

CORE
Physical Therapy and Sports Performance

Personal Information

Name: _____ Date of Birth: _____/_____/_____
(First name) (Last name) (Middle initial)

Address: _____
(Street) (City) (State) (Zip code)

Home #: _____ Cell #: _____ SSN #: _____-_____-_____

Please Circle one - Gender: Male | Female Marital Status: Single | Married | Divorced | Widowed

Email Address: _____

Employer: _____ Work Phone: _____

Emergency Contact: _____ Relationship to Patient: _____

Phone # _____

Insurance Information

Name of Insurance: _____ If Not Policy Holder Please Fill Out Below:

Name of Insured Individual: _____ SSN # of Insured: _____-_____-_____

Relationship to Patient: _____ DOB of Insured: _____/_____/_____

How did you hear about us? Friend | Family | Radio | Social Media | Other: _____

How would you like to receive information from us? (Circle one) Text | Phone Call | Email

Payment Policy and Financial Agreement

Thank you for choosing Core Physical Therapy & Sports Performance, LLC. for your Physical Therapy needs. This financial agreement describes both patient and insurance responsibility for services rendered. Please read this agreement, ask us any questions you may have, and sign in the space provided.

Insurance

Your insurance coverage is a contract between you and the insurance company and we are not a party to that contract. We must emphasize that as medical care providers, our relationship is with you, not your insurance company. It is also your responsibility to know your insurance benefits including referrals, pre-certifications and required authorizations. As a courtesy we will submit your claims to your primary and secondary insurance companies however we do expect payment for all services within 60 days. It may become necessary for you to pay your account in full if your insurance fails to do so within 60 days. If we are given incorrect or incomplete insurance information you will be billed and payment will be expected within 30 days, unless the issue is resolved.

Patient Responsibility & Payment

Payment of copays and deductibles will be ***DUE AT TIME OF SERVICE***. Our failure to collect these amounts may be a violation of our contract with your insurance company. You are ultimately responsible if your insurance denies a claim for any reason. If you do not have insurance, payment in full will be due at time of service at our private pay rate of $70 per session. The amount of your bill is expected to be paid in full within 30 days of the date on the statement, unless payment arrangements have been made with the Billing and Accounts Manager, or Billing Coordinator. Anything over 30 days is considered past due.

Payment Options – Credit Card on File

For your security and protection, Core Physical Therapy & Sports Performance, LLC. stores your encrypted and tokenized credit card data in an off-site, secure vault that exceeds all HIPAA and PCI Data Security Standards.

I authorize Core Physical Therapy & Sports Performance, LLC. to automatically debit the card on file for any patient responsibility, including standard co-pays, remaining balance, payment plans and no-show fees.

I understand that I can update my card information on file at any time by contacting our office directly. In fact, it is my responsibility to notify (Name of Practice) of any updates or changes to the credit card on file associated with this agreement as soon as possible.

Non-Payment

Failure to pay will result in your account being referred to a collection agency, which will affect your credit. NSF checks will result in a $25.00 returned check fee.

Insurance Benefits

(Primary)

Payable: _____ % (In-Network) Copay:_____

Deductible: _____/_____(met)

Out of Pocket:_____ /_____(met)

Limitations:_____

(Secondary)

Payable: _____% (In-Network) Copay: _____

Deductible: _____/_____(met)

Out of Pocket: _____/_____(met)

Limitations: _____

I have received this financial policy, and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts will be referred to a collection agency. If it becomes necessary to send my account to a collection service, You agree to reimburse

us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonably attorneys' fees, we incur in such collection efforts.

Patient Signature	Printed Name	Date
Parent/Guardian Signature	Printed Name	Date

Attendance Policy, Consent to Treat, Medical Records & HIPAA

Core Physical Therapy & Sports Performance, LLC. strives to provide each patient with the highest quality care while accommodating patient schedules. We reserve time slots for each patient in order to minimize waiting time and assure continuity of care. Your consistent attendance of the planned treatment regimen is paramount to your full recovery!

- Last minute cancellation and patient no shows decrease our ability to accommodate the scheduling of other patients in need, so if you are unable to keep a scheduled appointment, ***WE REQUEST 24 HOUR ADVANCE NOTICE***. Core Physical Therapy & Sports Performance, LLC. reserves the right to charge you a **$25 NO-SHOW FEE** for any missed appointments. Your insurance will not be billed for the visit.

- If you are going to be late for an appointment, please let us know as soon as you can. We will do our best to accommodate you; however, there may be times we will need to reschedule.

- We are required to document all cancellations and missed visits in your medical record and report it to your physician and insurance company/third party payer. If you accumulate three cancelled or missed visits, your therapist may refer you back to your physician before scheduling another appointment.

- If you are going to have a difficult time making your appointments, please discuss with your therapist. We will do our best to accommodate your needs.

Consent to Treat

I give permission for Core Physical Therapy & Sports Performance, LLC. to provide the medical treatment appropriate and necessary for the rehabilitation of (patient name) _____'s current physical condition.

Privacy

Core Physical Therapy & Sports Performance, LLC. understands that you have read and are aware of the current rules and regulations regarding Patient Rights and Responsibilities. If you are unaware of these policies, please ask us for a copy. Any changes to the HIPAA Privacy Act, effective April 14, 2003, or patient rights will be posted in our office. If you would read/review a full copy of the HIPAA policies it can be provided to you.

Medical Records Authorization

I hereby authorize direct payment to be sent to Core Physical Therapy & Sports Performance, LLC for Physical Therapy benefits if any, otherwise payable to me under terms of my insurance.

I hereby authorize Core Physical Therapy & Sports Performance, LLC to release any information acquired in the course of my examination or treatment.

I hereby authorize any physician, hospital, or medical facility to provide all information on my medical history and treatment to Core Physical Therapy & Sports Performance, LLC.

I authorize photocopies of this form to be as valid as the original.

** In addition to the doctor and insurance company on file I hereby authorize Core Physical Therapy & Sports Performance, LLC to release any information about me to:_____

I agree to and understand the above policies/procedures:

_____ _____

Patient/Guardian Signature Date

_____ _____

Facility Representative/Witness Date

Social Media | Print Marketing Consent Form

Social Media and printed materials are important communication platforms to help tell our story. Photos, Videos, and Quotes may be used in branded social media and printed marketing materials in an effort to promote the clinic. We respect the privacy of our patients and will only use included images, videos, and quotes of those who have given written permission.

By signing this consent I authorize **Core Physical Therapy & Sports Performance, LLC**. to use my photo, video, or quotes in Social Media, Radio, or TV marketing. By signing I also understand the following:

- I understand these photos, videos, and quotes may be able to be printed or shared.
- I understand that photos, videos, or quotes may be captioned and include my name
- I understand that I can revoke this agreement at any time by notifying **Core Physical Therapy & Sports Performance**, as applicable, in writing, and the revocation will be effective on the date notified.
- I understand that this authorization will expire in 5 years, unless otherwise notified.
- I understand that I will not receive direct or indirect payment for photos, videos, or quotes.
- I understand that I am allowed to inspect my photo, video, or quote before being published.
- I understand that by refusing to sign or participate will not affect my care or treatment at **Core Physical Therapy & Sports Performance.**

Print Name: _____

Signature: _____ Date: _____

Physical Therapy Pre-Exam Questionnaire

In order to evaluate your condition fully, please be as accurate as possible. Thank you.

Patient Name: _____ DOB: _____ Date: _____

1. What is your occupation? _____

2. Are you working now? ----------Yes | No ---------- Part-Time | Full Time

3. Physical Job Requirements: _____

4. Have you had physical therapy before? ---------- Yes | No

5. Where is your pain/problem? _____

6. Have you experienced this pain/problem before? ---------- Yes | No

7. What caused your pain/or problem? _____

8. Approximately when did it start? _____

9. Is it getting better, worse, or staying the same? _____

10. Is your pain constant (never goes away)? ---------- Yes | No

11. Pain Scale in the last 48 Hrs. (0=NO Pain , 5=MODERATE , 10=Worse Pain Ever Experienced)

When your pain is at its worst: 0…..1…..2…..3…..4….5…..6…..7…..8…..9…..10

How it feels right now: 0…..1…..2…..3…..4….5…..6…..7…..8…..9…..10

When your pain is at its best: 0…..1…..2…..3…..4….5…..6…..7…..8…..9…..10

12. Are you taking any medication for this pain/problem? ----------Yes / No

-If yes, what and does it help? _____

13. Are any of your usual everyday activities affected? ---------- Yes / No

-If yes, describes how: _____

Past Medical History

Please indicate whether you have had any of the following conditions:

Heart Disease or Attack ---------- Yes____No____
High Blood Pressure ---------- Yes____No____
Stroke ---------- Yes____No____
Epilepsy or Convulsions ---------- Yes____No____
Diabetes ---------- Yes____No____
Tumor or Cancer ---------- Yes____No____
Respiratory Disease ---------- Yes____No____
Pneumonia or Emphysema ---------- Yes____No____
Tuberculosis ---------- Yes____No____
Asthma ---------- Yes____No____
Hepatitis ---------- Yes____No____
Peptic Ulcer or Pancreatitis---------- Yes____No____
Anemia or other Blood Disorders---------- Yes____No____
Bleeding Disorders---------- Yes____No____
Hernia---------- Yes____No____
Thyroid Disease---------- Yes____No____
Are you Pregnant ---------- Yes____No____
Do you have a Pacemaker ---------- Yes____No____
Do you have any Surgical Implants ---------- Yes____No____
Are you a Smoker ---------- Yes____No____
Depression or Anxiety---------- Yes____No____
Mental Illness: Yes____No____If yes, Please Explain : _____
Any other Medical Conditions Not Listed: _____

Allergies

Please include ALL Allergies:
Penicillin or other Antibiotics ---------- Yes ____No____
Morphine, Codeine, or other Narcotics ---------- Yes ____No____
Novocaine, or other local Anesthetics ---------- Yes ____No____
Please list any other (i.e. Latex) _____

List Previous Surgeries:

_____
_____

List Current Medications:

_____
_____