Precision Physical Therapy Policies and Agreement

At Precision Physical Therapy of Fayette LLC, it is our goal to provide you with the most compassionate and individualized physical therapy care. With one-on-one appointments, our evidence-based evaluation and treatment approaches will allow for the highest quality outcomes and care, while restoring your prior level of function. The following policies regarding referrals, insurance coverage, scheduling, and appointments are to ensure that these goals are achieved promoting an exceptional physical therapy experience.

REFERRALS: As of July 2015, patients no longer need a referral to begin receiving physical therapy services in the state of Georgia. In fact, a referral is not necessary until after the 8th visit or 21st day of service following evaluation. If treatment is required beyond this time period, a referral must be obtained from another healthcare practitioner to continue treatment. A referral is required in order to receive dry needling services.

INSURANCE COVERAGE: Precision Physical Therapy of Fayette, LLC directly bills patients at time of service. Though we do not bill insurance, we encourage patients to utilize their "out of network" benefits when receiving our services. This allows the patient to submit documentation to their insurance provider for reimbursement, which Precision Physical Therapy of Fayette, LLC can assist with by providing necessary documentation. However, please be aware that there is no guarantee of reimbursement from insurance providers, and we are not held liable for remuneration.
At this time government funded insurance plans (Medicare, Medicaid, Tricare) will NOT pay for services rendered in an out-of-network setting unless they are preventative and wellness services.

SCHEDULING & APPOINTMENTS: The treating physical therapist and the patient will formulate a plan of care on the day of evaluation which will determine frequency of scheduled appointments. These appointments will typically last 1 hour and involve a combination of manual therapy techniques and therapeutic exercises. For patient convenience, we offer services in a private treatment setting at select local gyms, or we can come to the patient's office or home. **Please note: A no show or cancellation less than 24 hours in advance will incur a $50.00 charge.*

PATIENT CONSENT, ACCEPTANCE, AND AGREEMENT: I agree with the above written policies of Precision Physical Therapy of Fayette, LLC. I acknowledge and understand that I am personally responsible for payment at time of service. I give my consent for treating physical therapist to evaluate and treat at his/her discretion.

SIGNATURE: _____ DATE:_____

PRECISION
PHYSICAL THERAPY

MEDICAL INFORMATION RELEASE AND CONSENT FOR COMMUNICATION

I authorize the release of pertinent medical records or other information as needed in assistance with any medical claims process, as well as, situations which necessitate communication between Precision Physical Therapy of Fayette, LLC and other healthcare providers for the purposes of my care. This encompasses all forms of communication including but not limited to written documentation, telephone conversations, facsimile transmissions and email correspondence.

Patient Signature: _____ Date: _____

PRECISION
PHYSICAL THERAPY

Patient Contact Information

Name: _____ **Today's Date:**_____ **DOB:** _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Occupation: _____ **Recreation:** _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____ **Accept text: Yes / No**
Email: _____ **Accept email: Yes / No**

Emergency Contact Information
Name: _____ **Relationship:** _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____

Responsible Party Information (If applicable)
Name: _____ **Relationship:** _____
Address: _____
City: _____ **State:** _____ **Zip Code:** _____
SSN: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____

I/We authorize Precision Physical Therapy, LLC to release all medical information and/or records to my requesting insurance company and/or physician.

_____

Signature of Patient/Guardian **Date**

PRECISION
PHYSICAL THERAPY

Patient Health Questionnaire

Patient Name: _____

Today's Date: _____

Date of Birth; Age: _____

Gender: Male / Female

Primary Care Physician: _____

Referring Physician (If Applicable) _____

How did you hear about Precision Physical Therapy?

_____

History of current condition for which you are being treated?

_____

_____

Please list any tests/images completed for your current condition for which you are being treated and dates (ie. MRI, CT, Ultrasound, X-Ray):

_____

Have you received any other treatments for your current condition? (ie: PT, Chiropractic, Massage, Acupuncture)? If yes, Please list practitioner(s).

_____

What has had a positive effect/improved your complaint?	What has had a negative effect/worsened your complaint?

Please list *all* medical conditions and/or health concerns and any other pertinent medical information (including previous injuries).

_____

_____

_____

History of any of the following? (Check all that apply)

Head/spinal injuries		Recurrent headaches		Depression	
Meningitis		Stomach ulcers		Concussion	
Heartburn/Indigestion		Shortness of breath		Anxiety	
Anemia		Asthma		Loss of consciousness	
Bladder infections		Heart problems		Diabetes	
High Blood Pressure		Cancer		Stroke	
Blood Clotting Disorders		Smoking		Other pertinent conditions	

Do you or have you had any of these symptoms in the *past year*? (Check all that apply)

Change in bowel movements		Hot flashes		Persistent joint pain	
Irritable Bowel		Persistent nose bleeds		Blood in bowel/urine	
Vertigo/dizziness		Learning disability		Fatigue	
Difficulty concentrating		Muscle spasms		Lightheaded/fainting spells	
Eating disorder		Difficulty sleeping		Chest Pain	
Unexplained weight loss/gain		Pain at night		Unexplained Bruising	

Past Surgical History: Please list all past surgeries (please note year).

_____

Please list *all* medication/supplements you are *currently* taking.

_____

Please list all allergies.

_____

I/We authorize Precision Physical Therapy of Fayette, LLC to release all medical information and/or records to my requesting insurance company and/or physician.

_____

Signature of Patient/Guardian Date

Precision Physical Therapy

Web: http://www.precisionptllc.com
Phone: 770.598.4833
Email: Info@PrecisionPTLLC.com

Patient Name: _____ DOB: _____

Advance Beneficiary Notice of Noncoverage (ABN)

According to insurance regulations, Precision Physical Therapy is required to have patients sign an Advance Beneficiary Notice of Noncoverage (ABN) if treatment is not covered by their insurance plan or if they should choose to not submit or disclose to their insurance company. Insurance regulations are very specific that this decision MUST be made by patients without pressure from the medical provider.

Should you choose to receive treatment by Precision Physical Therapy, or if you choose to exercise your right to not send your information to your insurance company, please check the appropriate reason, as well as select the billing option described below.

Please check only one box; we CANNOT check the box for you.

I Am Electing To Receive Treatment For The Following Reason:

❑ Maximum Benefits Have Been Or Will Soon Be Reached	❑ I Do Not Have Insurance Coverage
❑ Treatment Is Categorized As "Not Medically Necessary" By My Insurance Carrier Or Physician	❑ I Knowingly Am Selecting Direct Payment For Services Covered By My Insurance Carrier
❑ I Do Not Want My Medical Information Released To My Insurance Company	

I Am Electing The Following Billing Option:

❑ I want the services offered by Precision Physical Therapy. I am aware and understand that I am responsible for the bill. I agree to pay Precision Physical Therapy at the time all supplies are received and services are rendered.

By signing below I understand and have received this notice. A copy of this notice will be provided to you.

Signature: _____ **Date:** _____