

Health. Wellness. Results.

Patient Information



Northern Physical Therapy Payment Policy & Billing Procedures

We strive to provide our patients with the utmost professionalism, excellence of service and the guarantee of privacy as mandated by section 164.520 of the HIPAA Privacy Rule (located at Front Desk). Our commitment to your well-being and gain of your physical abilities is something everyone at Northern Physical Therapy takes very seriously and we want you to understand your role in this process:

I understand that payment for all physical therapy services is my responsibility regardless of insurance or other third-party coverage.

I understand co-payment, deductible and co-insurance amounts are to be paid at the time of service. I agree to pay Northern Physical Therapy, PLLC for any unpaid portion of my bill upon request. In the event a check is dishonored, I am responsible to pay Northern Physical Therapy a \$35 returned check fee.

I authorize Northern Physical Therapy, PLLC to release to appropriate agencies, any information acquired in the course of my examination and treatment necessary to secure payment for services provided. I also understand that it is my responsibility to understand my health insurance policy and coverage and if special authorization from the insurance company is required prior to initiating physical therapy treatment.

Worker's Compensation and No Fault benefits will be verified however, this does not guarantee payment. In the event of denial, the account will become my responsibility. I can request that Northern Physical Therapy bill my primary insurance and I will be responsible for any unpaid portions of my bill.

If there is a balance on your account, Northern Physical Therapy will send you a statement. All balances are expected to be paid in full upon receipt of statement. Payment not received within 30 days are considered past due and will be subject to late fees and/or interest penalties.

Failure to maintain a current patient account may result in placement of your account with an outside collection agency. I, or my representative, understand and agree that in the event it should become necessary to place my account with an outside collection agency, I will be responsible for collections fees up to 30% of the principal balance owed. In the event that legal action becomes necessary to collect the balance due, I understand that I will also be responsible for attorney fees, interest, and court costs incurred.

Cancel/No Show Policy

_____(initials) This is to advise you of our cancel/no show policy. If you cancel or no show for a scheduled appointment without 24 hours notice, you will be subject to a \$25 fee. Please understand missing a scheduled visit limits others from receiving services for that day.

Signature of Patient or Guardian

Date

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*Patient Name: _____ *DOB: _____ *SS#: _____

If under 18, Responsible Party Name: _____

*Address: _____
(House Number and Street) (City) (State) (Zip Code)

*Primary Phone: _____ Cell Home

Secondary Phone: _____ Cell Home

Appointment Reminders:	
Primary OR Secondary	
<input type="checkbox"/> Call	<input type="checkbox"/> Call
<input type="checkbox"/> Text	<input type="checkbox"/> Text

*Email _____

*Is this a Worker's Comp Claim? Yes No

*Car Accident? Yes No

*Have you been covered under Home Healthcare? Yes No If Yes, date discharged: _____

*Primary Insurance: _____ Subscriber's Name: _____
DOB: _____ SS# _____ Subscriber ID#: _____
Relationship to patient: _____

*Secondary Insurance _____ Subscriber's Name: _____
DOB: _____ SS# _____ Subscriber ID #: _____
Relationship to patient: _____

To whom do you authorize us to disclose your personal health information?
Name: _____ Phone: _____ Relationship to Patient: _____

Do you have any known allergies to latex, lanolin, or beeswax? Yes No (Please inform staff of additional allergies.)

*Have you ever previously been a patient of NPT? Yes No

*Please indicate **any** ways that you have heard of NPT:

- | | | | | |
|------------------------------------|---|--|--------------------------------|---------------------------------------|
| <input type="checkbox"/> TV Ad | <input type="checkbox"/> Dr. Referral | <input type="checkbox"/> Family/Friend: (Who?) _____ | | |
| <input type="checkbox"/> Online Ad | <input type="checkbox"/> Seminar | <input type="checkbox"/> Sponsorship | <input type="checkbox"/> Event | |
| <input type="checkbox"/> Facebook | <input type="checkbox"/> I'm a Gym Member | <input type="checkbox"/> Radio | <input type="checkbox"/> Ad | <input type="checkbox"/> Saw Location |

Patient Signature: _____ Date: _____

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Have you EVER been diagnosed as having any of the following?

<input type="checkbox"/> Type 1 Diabetes	<input type="checkbox"/> Allergies, please list:
<input type="checkbox"/> Type 2 Diabetes	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Infectious Disease (Hepatitis, Tuberculosis)
<input type="checkbox"/> Emphysema/Bronchitis	<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> Hearing/Vision Impairment	<input type="checkbox"/> AIDS/HIV
<input type="checkbox"/> Seizures/Epilepsy	<input type="checkbox"/> Obesity
<input type="checkbox"/> Artificial joints, please list:	<input type="checkbox"/> Healing problems/open wounds, if yes then list:
<input type="checkbox"/> Dizziness or Vertigo	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> High or low blood pressure <input type="checkbox"/> Medicated?	<input type="checkbox"/> Rheumatic arthritis
<input type="checkbox"/> Mental illness/Depression	<input type="checkbox"/> Osteoporosis or Osteopenia
<input type="checkbox"/> Dementia	<input type="checkbox"/> Anemia
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Developmental or Growth Problems
<input type="checkbox"/> Angina or Arrhythmia	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/> Pacemaker or Stent	<input type="checkbox"/> Other Autoimmune Disease
<input type="checkbox"/> Vascular Disease	<input type="checkbox"/> Drug or Alcohol Dependency
<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Thyroid Problems (High or Low)
<input type="checkbox"/> Acute Respiratory Infection	<input type="checkbox"/> Acute Pulmonary Heart Disease
<input type="checkbox"/> Stroke	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Cancer If Yes, Date: _____	<input type="checkbox"/> Other
<i>Describe:</i>	
List Medication(s) or provide list with dosages:	List Medical/Surgical History:
Tobacco User: Yes ____ No ____	Body Mass Index: Weight: _____ Height: _____

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Patient Health Questionnaire - PHQ

Describe your symptoms: _____

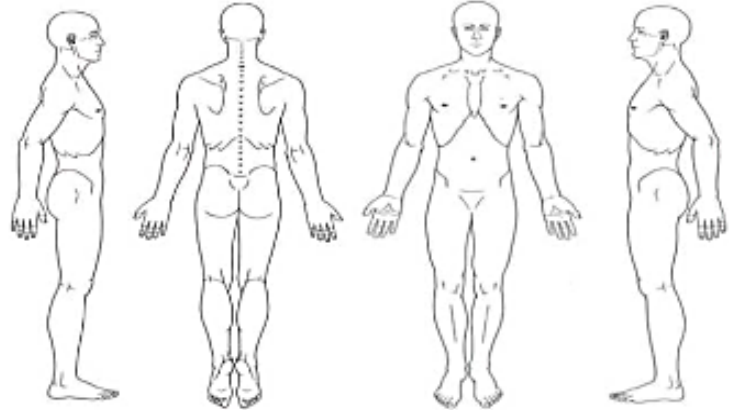
When did they start? _____

How did they begin? _____

How often do you experience your symptoms?

- ① Constantly (76% - 100% of the day)
- ② Frequently (51% - 75% of the day)
- ③ Occasionally (26% - 50% of the day)
- ④ Intermittently (0% - 25% of the day)

Indicate where you have pain or other symptoms:



What describes the nature of your symptoms?

- ① Sharp
- ② Dull Ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

During the past 4 weeks:

Indicate the average intensity of your symptoms:

- None Unbearable
- ①
 - ②
 - ③
 - ④
 - ⑤
 - ⑥
 - ⑦
 - ⑧
 - ⑨
 - ⑩

How much has pain interfered with daily tasks?

- ① Not at all
- ② A little Bit
- ③ Moderately
- ④ Quite a bit
- ⑤ Extremely

How much of the time has your condition interfered with social activities?

- ① Rarely
- ② Occasionally
- ③ Regularly
- ④ Frequently
- ⑤ Always

How would you rate your overall, general health? ① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

Who have you seen for your symptoms? _____

What treatments have you received, and when? _____

What tests have you received, and when? (Xrays, CT Scan, MRI, etc.) _____

Have you had similar symptoms in the past? Yes No

If so, who did you see for treatment? _____

If you are not retired, a homemaker, or a student, what is your current work status?

- Full-time
- Part-time
- Self-Employed
- Unemployed
- Other

What is your occupation? _____

Patient Signature: _____ Date: _____

Diagnostic Testing Screening Tool

Patient Name: _____ Date: _____

If you currently feel or have felt any of the following symptoms within the past month, or if you have been diagnosed with any of the following conditions, please check the appropriate boxes.

This is a screening tool that can help your Therapist determine what diagnostics tests* may be appropriate for you.

Please check all that apply:

Section 1:	
<input type="checkbox"/> Low Back and Radiating Pain	<input type="checkbox"/> Neck Pain and Radiating Pain
<input type="checkbox"/> Numbness, Tingling, or Burning Sensation in the Legs or Feet	<input type="checkbox"/> Numbness, Tingling or Burning Sensation in the Arms or Hands
<input type="checkbox"/> Weakness in the Legs or Arms	<input type="checkbox"/> Loss of sensation in Hands/Feet
<input type="checkbox"/> You have Diabetes or Neuropathy	<input type="checkbox"/> Daily alcohol 3 glasses or more
<input type="checkbox"/> Thyroid Dysfunction	<input type="checkbox"/> Muscle Disease/Muscle Cramping
Section 2:	
<input type="checkbox"/> Tendinitis/Bursitis/Arthritis	<input type="checkbox"/> Shoulder Pain or Instability
<input type="checkbox"/> Elbow Pain or Instability	<input type="checkbox"/> Wrist-Hand Pain or Instability
<input type="checkbox"/> Hip or Knee Pain or Instability	<input type="checkbox"/> Ankle-Foot Pain or Instability
Section 3:	
<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Hearing Problems
<input type="checkbox"/> Dizziness or Vertigo	<input type="checkbox"/> Headaches
<input type="checkbox"/> Unsteady Gait	<input type="checkbox"/> History of falls due to dizziness
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Hypotension
<input type="checkbox"/> Anything else you consider important:	

Patient Signature: _____

*Electromyography/Nerve Conduction Studies, Autonomic System Testing, Somatosensory Evoked Potentials, Auditory & Visual Evoked Potentials, Musculoskeletal Ultrasound, Vestibular Testing.