SISSON & ASSOCIATES PHYSICAL THERAPY AND WELLNESS

17248 KINGS HIGHWAY MONTROSS, VA PHONE 804-493-0002 FAX 804-493-0004

Name:____DOB: _____/_____/_____

Address/City/State/Zip:____

Home Phone:_______________________Cell Phone:____________________________Email:________________________

How did you hear about us?

□ Referring Provider (Medical or Wellness)_______________________________

□Friend___________________________________

□ Family member __________________________________ □ Newspaper Column

□ Newspaper Ad □ Flier □ Facebook □ Google □ Other________________________________

Have you downloaded our Back-Pain Check List online? Yes ☐ No ☐

Height: _____ ft. _____ inches _________ Weight: _____ lbs

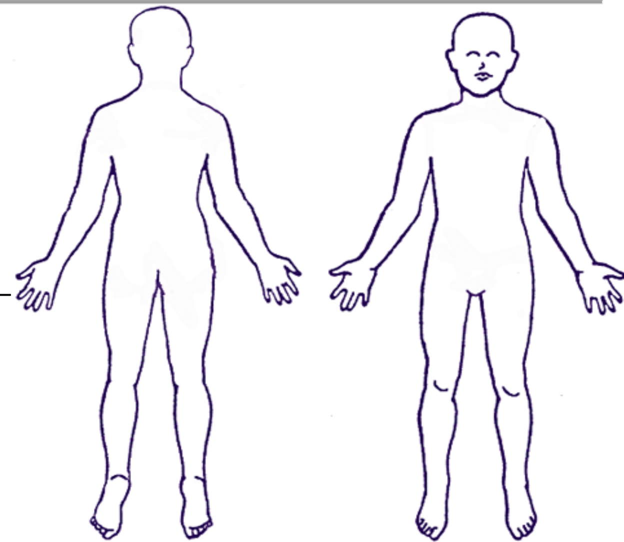
Symptoms began on: ___/___/______.

How did symptoms start? _______________________________________

____

What worsens symptoms: ____

What improves symptoms: _______________________________________



Indicate where you have symptoms

Average pain intensity

Last 24 hours:	No pain	■ ■ ■ ■ ■ ■ ■ ■ ■ ■ 1 2 3 4 5 6 7 8 9 10	Worst pain
Past week:	No pain	■ ■ ■ ■ ■ ■ ■ ■ ■ ■ 1 2 3 4 5 6 7 8 9 10	Worst pain

How often do you experience your symptoms?

□ Constantly □ Frequently (51-74%) □ Occasionally (26%-50%) □ Intermittently (0%-25%)

Have your symptoms gotten better, worse, or same since onset? _______________________________

In general, would you say your overall health right now is…? □ Excellent □ Very Good □ Good □ Fair □ Poor

What is this condition most limiting you from doing that you need, want, or love to do?

____

____

Do you now have or have you ever had any of the following?

Chest pain	□Yes □No	Hypertension	□Yes □No	Anxiety	□Yes □No
Short of Breath	□Yes □No	Osteoporosis	□Yes □No	Depression	□Yes □No
Heart attack	□Yes □No	Sexual Dysfunction	□Yes □No	Infectious diseases	□Yes □No
Other heart trouble	□Yes □No	Arthritis	□Yes □No	Past Surgery	□Yes □No
Diabetes	□Yes □No	Numbness/tingling	□Yes □No	Hernia	□Yes □No
Cancer	□Yes □No	Bowel/bladder issues	□Yes □No	Feel weak/unwell	□Yes □No
Unintended weight loss	□Yes □No	Headaches	□Yes □No	Pregnant	□Yes □No

Authorization for Payment

I certify that the payment information given by me in applying for payment is correct. I authorize the release of all medical records to act on this request. I request that payment of authorized benefits from Medicare or other responsible payor be made in my behalf to Sisson & Associates, LLC. I understand that I am responsible for all amounts not paid by my insurance including, but not limited to, co-payments. If I am a Private Pay patient, I agree to pay for all services rendered by Sisson & Associates, LLC.

If Medicare is my primary Insurance, I understand that I must follow up with my referring physician once every 60 days from the date of my initial physical therapy evaluation.

Authorization for Release of Information

I acknowledge the receipt of the Notice of Privacy Practices and was given an opportunity to ask questions. I understand that Sisson & Associates may use or disclose protected health information about me to carry out treatment, payment, or other health care operations. I authorize and give my permission to Sisson & Associates to release and/or receive any of my past and/or current medical information that is necessary for the coordination and continuation of my care. Further, this authorization and release applies to the furnishing of any and all information required to establish my claim for benefits with my insurance company or any government agency from which I claim benefits in payment of my bills from Sisson & Associates. I have reviewed the HIPPA Notice and I am aware of the posted notice in the clinic. This authorization will be considered ongoing and effective unless it is specifically revoked in writing by me or my legal representative. I hereby give my permission for the review of my medical record by any of the clinics regulatory bodies.

Consent for Treatment

I hereby give my permission for the authorized personnel of Sisson & Associates to perform all necessary procedures and treatments within their scope of practice. I am aware that I can refuse treatment or terminate services at any time.

Patients Printed Name: ______________________________ Date: ____________________

Patients Signature: ______________________________

Signature of Guarantor or Power of Attorney (if applicable) ______________________________

FINANCIAL POLICY

Please *carefully* review our Financial Policies. It is important for you to have a thorough understanding of your physical therapy benefits and responsibilities.

NO INSURANCE / CASH RATE: Sisson & Associates offers a cash rate to those who do not have insurance coverage, or who have maximized their benefits. We also will accept cash payment if you do not wish to involve your insurance at any point in time.

MEDICAL INSURANCE COVERAGE: Sisson & Associates participates in some health plans, but not all. At the time of your initial visit, we will attempt to verify your current insurance coverage. Should we be out-of-network with your insurance, we do offer out-of-network billing if your plan allows. It is ultimately your responsibility to know your physical therapy benefits and all coverage is based on insurance coverage at the time of service, and you are responsible for any amount not covered under your insurance plan. NOTE: Verification of PT benefits is <u>NOT</u> a guarantee of payment.

CO-PAYMENTS, COINSURANCE AND DEDUCTIBLES: For clients with in-network coverage, copayments will be collected at the time of the appointment. You may request that they be billed to you at the conclusion of your plan of care; however, for this option, we do insist that you provide a valid debit or credit card be placed on file to secure those payments following your discharge. If you're insurance is considered out-of-network, the copayments/coinsurance will be billed to you following your discharge.

UNPAID BALANCES: We offer payment plans up to 6-months following the date of discharge for those with no-insurance/out-of-network insurance. Account balances over 60 days without a payment or payment agreement will be subject to assignment to an out of office collection assistance agency or law firm. Should this be necessary, collection and attorney fees will be added to your account.

I have read and agree to the financial policies of Sisson & Associates. I understand I am ultimately responsible for payment of my account with Sisson & Associates regardless of my insurance coverage.

Patient's Signature: _________________________________ Date: ______________________

PHYSICAL THERAPY ATTENDANCE & CANCELLATION POLICY

(Please read thoroughly)

Sisson and Associates Physical Therapy and Wellness takes pride in reserving a 1-hour time slot specifically for you, one-on-one with a licensed specialist, who will design a plan of care to meet your specific needs and provide you with the most powerful results.

In order to reach your goals with ease, it is imperative that you commit to the plan the doctor has prescribed for you by maintaining consistent attendance. Our office will attempt to accommodate your schedule for your convenience.

While we are sensitive to the fact that an emergency may occur in a rare instance, cancellation, especially those last minute, along with patient no-shows, decrease our ability to accommodate the scheduling needs of other patients. Additionally, last minute cancellations and no-shows display a lack of respect for your doctor and fellow patients. Therefore, we must ask for your full cooperation with the following **<u>48-HOUR CANCELLATION POLICY</u>**:

- Failure to show to your scheduled appointment, cancelling or rescheduling without

48-hour notice will result in a cancellation fee totaling at 80 percent of the session rate (this policy applies regardless of other physician appointments).

- Sisson & Associates reserves the right to charge you this fee should you fail to notify the office 48-hours prior to your appointment without adequate cause at its discretion.
- We understand that sometimes you'll be late to your appointment; however, please keep in mind that late arrivals of 20 minutes or more may result in the appointment being cancelled and the cancellation fee applied.
- Cancellation fees MUST be collected prior to the start of the following scheduled appointment. INSURANCE DOES NOT APPLY TO CANCELLATION OR NO-SHOW FEES; THE CLIENT IS SOLELY RESPONSIBLE FOR THESE PAYMENTS.
- Three (3) consecutive no-shows or cancellations will result in the cancellation of all remaining scheduled appointments.

We believe that this policy is necessary for the benefit of all our patients, so that we may continue to provide the high-quality care our practice is known for.

Our staff at **Sisson & Associates** appreciates your cooperation with this policy. We are so excited to have you on board and to help you in this journey to attain your goals in the coming treatments.

_____________________________________ __________ / _________ /_________

Patient Acknowledgment/Signature of Agreement **Date**

Card on File: Authorization Form

Information to be completed by cardholder:
The undersigned agrees and authorizes medical practice to save the credit card indicated below on file. The use of this form is optional and for your convenience.

Medical Practice: ____

Patient's Name: ____

Name as it Appears
on the Credit Card: ____

Type of Credit Card: ☐ MasterCard ☐ Visa ☐ Discover ☐ Amex

Front Digits on Card: ____________________

CVV (3 or 4 digit code): ____________________

Expiration Date: ____________________

I, ____ authorize the above medical practice to process the above credit card as "Card on File". I understand this authorization will remain in effect until the expiration of the credit card account. Patient may also revoke this form by submitting a written request to the medical practice.

___________________________________ ____________________

Cardholder's Signature Date

PAYMENT PLAN CONTRACT AGREEMENT

I, _______________________________, hereby agree to participate in the Sisson & Associates, LLC payment plan set forth in this contract. I understand and agree to the requirement of having a valid credit card stored on file and charged for payment on the dates noted by the office manager at the time of my discharge.

I understand that Sisson & Associates will attempt to bill my insurance company in accordance with its financial policy. I understand that explanation of benefits is not a guarantee of payment on behalf of my insurance company. Therefore, I do know and agree that I am solely responsible for the full payment of these services regardless of my insurance coverage at the time of service.

I understand that a payment will be billed automatically to my credit/debit card each month on the date that I agree upon with the office manager at the time of discharge. I understand that I am able to choose the duration of my payment plan, not to exceed 6-months, and the payments will be billed at an equal percentage of the standard rate. (Example: A 2-month payment plan will be billed at 50 percent of the grand total of all sessions. A 3-month payment plan will be billed at 30 percent of the grand total of all sessions until the full payment is completed.)

When using a credit card, I understand that if insufficient funds are present at the time of withdrawal on my scheduled payment date, I understand that I am responsible for obtaining funds within 72 hours or legal actions may be taken. Should legal actions need to be taken, I will be responsible for any attorney or collection fees that me incur.

I understand that if I choose to prematurely end my plan of care for any reason that I may be responsible for providing the full payment on the last day of the discharged month, unless otherwise noted from Sisson & Associates.

Once the full payment amount has been applied, I understand that Sisson & Associates will immediately discard of my credit card information unless I specify otherwise.

Choice of Plan Duration: ____

Patient's Signature: ____

Date: ____