***BACKWAY'S PHYSICAL THERAPY, PLLC*: Speech & Language Therapy**
Insurance Client Information Form

Welcome to our Practice! ***Sorry these forms are lengthy**, but they will assist us in fully evaluating your condition and establishing a meaningful treatment plan for you. Please fill them in to the best of your ability.*

NAME_____**AGE**_____**BIRTHDATE**_____**HT**_____**WT**_____**SEX**____

ADDRESS_____**CITY**_____**STATE**_____**ZIP**_____

Phone: Home_____ **Work**_____ Ext_____ **Cell** _____

Email: _____ **PROFESSION**_____

MARITAL STATUS: S M W D Sep. **Spouse's Name**_____

YOUR SOC. SEC.#_____-_____-_____ **SPOUSE'S SOC. SEC.#**_____-_____-_____

EMERGENCY CONTACT: Name: _____Phone#_____

DOCTORS' NAMES & PHONE #

1ST Dr.	2ND Dr.
Phone #	Phone #

Have you received any physical therapy, speech therapy, home health care or hospice care services? ❑Yes ❑No
If yes, when? _____ Please explain: _____
_____

INSURANCE INFORMATION:

✶✶ ***Please be sure to bring your insurance cards and your picture ID with you.*** ✶✶
The law requires that we copy them.

HEALTH INSURANCE: *(Please write the Insurance Co. name, but only list the other information if it differs from your Card.)*

Primary Insurance Company Name:	**Secondary/Supplemental Insurance Company Name:**
Insured's Name:	**Insured's Name:**
Insured's Date of Birth:	**Insured's Date of Birth:**

RESPONSIBLE PARTY (If not you, who will be responsible for paying the bill?)
Name_____ Relationship To You_____
Address_____Zip_____
HomePhone#_____WorkPhone#_____Ext_____
****

We believe that patients who understand and participate in their health care will achieve the best results. We respect your individuality, your rights, and your privacy, and we will give you the best care we possibly can.
Please read the following, and sign below. [Page 9 contains further details on our Financial and Office Policies]

Financial Responsibility: You are responsible for paying your deductible and your co-pay/co-insurance at each visit. If you cannot afford to pay, you will be expected to set up, and adhere to, a payment plan. Late fees may be charged on overdue account balances if you miss making regular payments. A fee of $25 will be charged on bank-returned checks.

Missed Appointments: If you need to cancel an appointment, let us know before 8AM of the day prior to your scheduled appointment. If you cancel late, or if you do not attend your appointment, **you will be charged** a missed-appointment fee.

I have read the two statements above, and understand them. I hereby consent to treatment by Backway's Physical Therapy, PLLC.

Signed_____**Date**_____

Speech and Language Therapy: Initial Appointment Questionnaire: Present Problems

*It is important that you inform us of **ALL** medical/health conditions at your first appointment, and immediately inform us of any changes in your medical/health condition during your course of treatment.*

***The following forms** will tell us about your health conditions, medications, your insurance & contact information. Some of the forms ask for your signatures to give us permissions for billing, treatment, and communication purposes; and for signatures to indicate that you understand how your insurance, our billing, and the Privacy Act (HIPAA) work.*

*Please answer these questions to the best of your ability. **If something is confusing, leave it blank.***

Information About What Brought You Here:

How did you hear about our services? _____

What are the main symptoms that bring you to Speech Therapy today? _____

_____

Are you seeking treatment for? (Please circle all that apply)

SPEECH VOICE SWALLOWING COGNITION APHASIA (language trouble)

Onset: When did your symptoms begin? _____

Was the onset sudden or was the onset gradual? _____

Previous Treatment: Have you had any previous **Speech Therapy** treatment for these symptoms?

Yes _____ No _____ If "yes," please describe_____

Other Services:

Have you received any **physical therapy, speech therapy, home health or hospice care services in the past year?** Yes _____ No _____ If yes, when? _____

Please explain: _____

_____

Please give names of *all* other Health Care Professionals you are seeing:

(Example: name of your Physical Therapist, Occupational Therapist, Psychologist, ENT, etc.):

_____

_____

Previous Level of Function: What were you able to do before these symptoms began, that you cannot do now?

_____

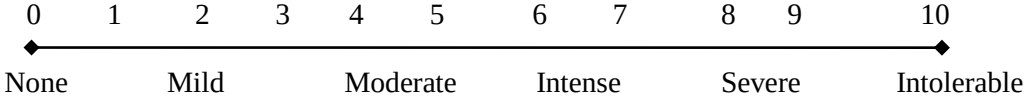
_____

Goals: What results do you want from Speech Therapy? _____

_____

Symptoms:

Please indicate on the scale below the intensity of your symptoms or pain:



Speech & Language Therapy: Initial Questionnaire: *Health History*

Please indicate if you now have, or in the past had, any of the following (check all that apply):

Voice & Speech
- ❑ Slurred / Mumbled Speech
- ❑ Voice Problems or Changes
- ❑ Naming Problems
- ❑ Difficulty Understanding
- ❑ Illegible Writing
- ❑ Other: *(write in any other complaint)*

Nervous System
- ❑ Head / Traumatic Brain Injury
- ❑ Stroke /TIA's
- ❑ Memory Loss
- ❑ MS
- ❑ Parkinson's
- ❑ Alzheimer's Disease
- ❑ Dementia
- ❑ Peripheral Neuropathy
- ❑ Epilepsy / Seizure Disorder
- ❑ other Neurologic problems *(list)*

Respiratory System
- ❑ Asthma
- ❑ Emphysema or COPD
- ❑ Pneumonia
  How Recently? _____
- ❑ Sinus surgeries
- ❑ Allergies
- ❑ other Lung problems *(list)*

Cardiac / Circulation System
- ❑ Heart Attack
- ❑ Angina or Chest Pain
- ❑ Irregular Heart Rhythm
- ❑ Anemia
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Heart Surgery
  When _____
  What _____

Digestive & Eliminatory
- ❑ Swallowing Problems
- ❑ Changes in Appetite
- ❑ Unexplained Weight Change
- ❑ GERD / Heartburn / Reflux
- ❑ Esophageal Dysmotility/Strictures
- ❑ History of Feeding Tube
- ❑ Disordered Eating
- ❑ Difficulty Chewing
- ❑ IBS
- ❑ Frequent Loose Stools
- ❑ Frequent Constipation
- ❑ Hiatal Hernia
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Urinary Incontinence

Endocrine & Immune System
- ❑ AIDS
- ❑ HIV positive
- ❑ Hepatitis A B C (circle)
- ❑ Diabetes Type 1 or 2 (circle)
- ❑ Thyroid Imbalance
- ❑ Low Blood Sugar
- ❑ Head and Neck Cancer
- ❑ Cancer (other)

Please describe:

Musculoskeletal & Connective Tissue Conditions
- ❑ Osteoarthritis
- ❑ Spinal Stenosis
- ❑ Herniated Disc Neck
- ❑ Osteoporosis or Osteopenia
- ❑ Compression Fractures
- ❑ Rheumatoid Arthritis
- ❑ Lupus
- ❑ Gout
- ❑ Fibromyalgia
- ❑ Migraine
- ❑ Frequent Headaches
- ❑ TMJ
- ❑ Teeth Grinding
- ❑ Other: *(list)*

General Challenges
- ❑ Falls. If yes, more than 2 in a year? ❑
- ❑ Shortness of Breath
  - ❑ on exertion ❑ at rest
- ❑ Dizziness
- ❑ Balance Disturbance
- ❑ Hearing Loss
- ❑ Vision Loss
- ❑ Sleep Apnea
- ❑ Insomnia
- ❑ Unusual Fatigue
- ❑ Alcoholism
- ❑ Substance Abuse (current or past)
- ❑ Clinical Depression
- ❑ Mental or Emotional disorders

Please Explain:

Surgeries, Traumas, Other Illnesses, Accidents & Hospitalizations:

Please list any other information regarding your medical or health history that you believe we should know.
*Please include approximate dates **or** your age at the time.*

Thank you *for providing this information for us. Please, let us know of any health changes.*

Patient name: _____ Date: _____

Have you fallen in the past 12 months? ❑Yes ❑No **How many times?** _______ **Were you injured from falling?** ❑Yes ❑ No

Please look at the labels on your medications & supplements; then list them below. This includes all prescription, over-the-counter, herbals, vitamins, minerals and dietary/nutritional supplements you take routinely, and/or on an as-needed basis.

Medication or Supplement Name	Dosage	How many times/day?	Is this taken by mouth or other route?	What condition is this for?	"May cause dizziness" label on it?	Does this med make you dizzy?
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No

Therapist notes: Is form complete? ❑ Yes, ❑ No. If no, reason not completed: ❑ Pt refused ❑ Emergency ❑ Pt cog unable **(initials: ________)**

Patient Name: ____ **Date:** _______________________

Backway's Physical Therapy, PLLC **AUTHORIZATIONS & CONSENTS FORM**

You have the right to revoke the following authorizations, unless we have already taken action relying on the authorization. Requests to revoke any authorizations must be made in writing. _____ (please initial)

****

***Optional*: Consent for Use of Information for Presentations, Research and/or Publications (optional)**

I grant permission, now and in future, to Backway's Physical Therapy, or their duly appointed representative, to use my records, or those of my dependent, for other consultations and for professional education, research and publications, **providing reasonable precautions are taken to guard against the disclosure of the client's identity**. My signing of this authorization is **not** a condition to receive treatment by Backway's Physical Therapy personnel.

(Optional) Patient's/Guardian's Signature _____Date _____

****

All Authorizations below are Mandatory:

Authorization for release of information to Insurance Company & for payment from Insurance:
I authorize the staff of Backway's Physical Therapy to release information acquired in the course of my evaluation and treatment to my insurance company as needed to determine the benefits payable for the related service; and I request that any payment of authorized insurance benefits be made on my behalf to Backway's Physical Therapy, at their business address, for all services furnished that were not paid in full by me at the time services were rendered. **(_____ initials)**

Authorization for "Signature on File:" I authorize the staff of Backway's Physical Therapy to submit completed claim forms to my insurance company using the notation "signature on file" to indicate that I have signed this Authorizations Form. This one-time signature is valid for claims resulting from this and future services provided to me by Backway's Physical Therapy, PLLC. **(_____ initials)**

Authorization to leave Messages: In the event that Backway's Physical Therapy cannot speak to me in person regarding the appointments or evaluation results, I give permission to Backway's Physical Therapy to contact me and leave a message on *(check all that apply)*: **(_____ initials)**

Answering Machine _____ Cell Phone _____ or other location_____

Consent for Mutual Exchange of Information: I authorize the mutual exchange of information regarding myself, or my dependent, between the Backway's Physical Therapy staff members, and all professional practitioners involved in my healthcare, or that of my dependent, at any time (i.e. doctor, chiropractor, counselor, etc). Your office may also talk with the non-practitioner persons listed below about my health information: **(_____ initials)**

□ Spouse	Name:	phone#:
□ Child	Name:	phone#:
□ Parent	Name:	phone#:
□ Other	Name:	phone#:
□ Other	Name:	phone#:

Consent for Treatment: I hereby authorize the professional staff of Backway's Physical Therapy to evaluate and treat me or my dependent. During the course of evaluation and treatment, I authorize the licensed personnel at Backway's Physical Therapy to use any and all techniques they have been trained to use, which they believe will benefit me, in order to help me recover. I have the right to refuse a specific technique or form of treatment, if I so choose. **(_____ initials)**

Receipt of HIPAA Patient Privacy Notice: My signature below indicates that I have received the HIPAA Patient Privacy Notice. I consent to your use and disclosure of protected health information about me for treatment, payment, health care operations, and/or as required by law and by HIPAA. **(_____ initials)**

➔**Patient's/Guardian's Signature** _____ Date _____

Patient name: _____ Date: _____

Backway's Physical Therapy, PLLC **FINANCIAL, BILLING & OFFICE POLICIES**

At Backway's PT, we are committed to assisting you, even with billing your insurance company. It is important that you realize **our relationship is with you, *not*** your insurance company. *Please* read these financial, billing and office policies to understand what we expect from you in this process; then sign below.

1. **Insurance:** We participate with most insurance plans, but not all of them. Each insurance company has many different plans, so we cannot know exactly what your plan covers. Therefore, it is **your** responsibility to know your insurance benefits. If you don't know, please call your insurance company and ask: What are my benefits for Physical or Speech Therapy? What is my deductible & has any been met? What restrictions or limits apply to my care? What is not covered? What is my copayment amount or coinsurance percent?
2. **Insurance Verification:** ***As a courtesy***, we call your insurance company to verify your insurance coverage. However, all insurance companies tell us the information they give us is "an estimate and is not a guarantee of coverage or benefits." Since your insurance company does not take responsibility for the information they provide to us, we cannot be sure of your coverage until they **actually process** your claim. ***Because of this*, we cannot guarantee** payment of claims by your insurance company.
3. **You are responsible**. You are responsible for making sure your account is paid in full. Filing of all insurance claims, other than Medicare, is a **courtesy** provided by this office. We will assist you in any way we reasonably can to help get your claims paid. If your claim is reduced or denied by your insurance company, or you exceed your limits of coverage, you will be responsible for paying the balance on your account, up to your insurance company's normally allowed amount.
4. **Non-covered & Disallowed services:** Many health insurance companies do not allow or pay for supplies & maintenance services. Additionally, unbeknownst to us, in some rare cases, a portion, or all of the services you receive may not be covered or may be considered "not reasonably necessary" by your insurance plan. Because of this, we will bill you, and you agree to pay for services and/or supplies which may be denied as "non-covered" by your insurance plan.
5. **Payment is due at time of service**.
   ✶*Cash, check & credit card payments accepted with an added fee for use of a credit card.* ✶
   Credit Card payments are accepted for $50 or more, and are subject to an added $5 PayPal fee.
   You are responsible for paying your deductible, co-payment or coinsurance amount at the time of service. This arrangement is part of your contract with your insurance company.
   If you do not have sufficient funds to pay at the time of the visit, we expect payment to be made within 10 days of the visit, ***whether or not you receive an invoice from us.***
   ✶✶***If you have financial problems that affect your ability to make timely payment on your account***, please discuss this with us before or at the time of service, so that you can make payment arrangements. ✶✶
6. **Overdue Accounts**: All overdue accounts are subject to late fees. Amounts billed to your insurance company are considered overdue 30 days after they process a specific service date (even if this processing did not result in payment for that service date). Liens start accruing fees 90 days after discharge from therapy.
   Late fee tabulation:

Past Due Balance	$20 - $100	$101 to $750	$751 to $3000	Greater than $3000
Monthly Late Fee	$15	$25	$50	$75

   Returned check fee: A fee of $25 is charged on all returned checks.
   Collections: Returned checks and failure to pay account balances overdue for 90 days may result in our referring your account to an outside collection service.
7. **Missed appointments:** this policy was already stated at the bottom of page 1.
8. **We may refuse service** to a client under certain circumstances. Refusal is usually due to, but is not limited to: non-payment of past accounts; repeated missed/canceled appointments; inappropriate or belligerent behavior; and the therapists' opinion that our services won't benefit a client or aren't medically necessary.

I have read and understand the financial, billing & office policy information presented above.

Signed_____ Date_____

Patient Name: _____