Patient Information Form

1. **Personal Information**

First Name: ___________________________ Last Name: ________________________ DOB: ________

Street Address: ______________________________ City: ________________ State: __________ Zip: __________

Phone: ____________________ Can we leave a message? Y N Email: _______________________________

Emergency Contact: ______________________ Relationship: _______________ Phone: __________________

Do you have any pets in your home? Y N If yes, please describe: ____

2. **Physician Information**

Primary Care Physician: ________________________ Referring Physician: ________________________

Movement Disorder Specialist/ Neurologist (if applicable): ______________________________________

3. **Please tell us about your diagnosis**

What is your diagnosis? Parkinson's Disease, Other Parkinsonism, Stroke, Other? If other, please explain:

____

When did you receive this diagnosis or when was the onset of your condition?

____

Are you receiving other therapy currently or belong to any support groups, exercise groups, etc.?

____

Have you had any falls in the past year? Y N Have you had any falls in the past 3 months? Y N

Do you have any pain? If so, please explain:

____

4. **Quality of Life**

In this section please rate your answers on a scale from 0-10 where zero is the least and ten is maximum

Rate your SLEEP QUALITY: __________________ Rate your DAYTIME FATIGUE: _______________________

Rate your STRESS LEVEL: ____________________ Rate your ANXIETY: _______________________________

Rate your FEAR OF FALLING: _________________ How many 8oz glasses of water do you drink/day______

5. **Please tell us a bit more about yourself and your experience with exercise**

What are your top 2 goals that you would like our help to achieve? ____

____

What types of therapy and/or exercise have you tried in the past? ______________________________________
____

What are you currently doing for exercise, if any? ____
____

Is there anything else we should know? ____
____

6. Medical History

Please list all your medical and surgical history ____
____
____
____

Please list all your medications and supplements (You may provide a separate list to attach if you prefer)
____
____
____

7. Insurance Information

Primary Insurance Company______________________________ Member ID: _______________________________

Secondary Insurance Company: ___________________________ Member ID: _______________________________

8. How did you hear about Thrive Physical Therapy? ____
____

____ ___________________________
Patient Signature **Date**

Outpatient Physical Therapy - At Home
Serving Greater Rochester
585-851-8259
585-310-2761
info@ThriveRochester.com
www.ThriveRochester.com

Payment Agreement

Thank you for choosing Thrive Physical Therapy, PLLC as your physical therapy provider. Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

- You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.
- Payment is expected at time of service unless you have made other payment arrangements with us.
- **Out-of-Network Policy.** (Commercial Health Plans - Does not apply to Medicare) If we are out-of-network with your health plan and you have out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. You are responsible for contacting your insurance company to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.
- **Medicare Part B Policy.** We are enrolled as a participating provider with Medicare Part B. As such, our charges for Medicare covered benefits are limited to Medicare's fee schedule for participating providers. Medicare's fee schedule only applies to the services that meet all of Medicare's Conditions for Payment and Medicare pays for the service. You understand and agree that you have been fully informed in advance about what interventions and/or services, if any, are not covered by Medicare and therefore not subject to Medicare's fee schedule for participating providers and have agreed to pay our charges for those services. This includes services which are not paid by Medicare because the service is not covered or Medically necessary. We may ask you to sign an Advanced Beneficiary Notice if we don't believe Medicare will cover a service you have chosen to receive.
  - **Medicare Advantage Plans ("MAP").** If we are out of network with your MAP and your MAP offers out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your MAP for reimbursement for the services your health plan covers. You are responsible for contacting your MAP to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your MAP denies, in whole or in part, your claims for our services.
- **Wellness & Fitness Services.** Commercial health plans and Medicare do not cover the wellness or fitness services we offer. Therefore, we will provide you with a receipt for these services upon request.
- **Service Packages.** If you purchase a discount package of services, the package discount is applied to the last visit in the package. You must use your visits within 12 months. If you don't use your visits within that time frame or you request a refund for the unused visits, we will refund the excess amount paid, if any, after applying the package discount to the last visit and our regular cash payment fee to all other visits.
  - **Use of Health Savings Accounts (HSA).** If you purchase a pre-paid package plan through your

HSA account we will give you a receipt for the pre-paid services that you can, at your discretion submit to your HSA plan in accordance with your HSA plan rules. If you request a refund for unused services that you paid for through your HSA, we will make the refund directly to your HSA account. If your HSA requires you to actually receive the services before submitting claims for reimbursement, we will provide you with a receipt for services actually received to date upon request. You are responsible for complying with HSA rules when determining whether the services you purchase from us can be paid from an HSA account.

  - **Use of Health Reimbursement Arrangement (HRA) or Flexible Spending Account (FSA).** An HRA and FSA will only reimburse for actual services received (not pre-paid services). Therefore, if you purchase a discounted pre-paid package plan and want your HRA or FSA to reimburse you, we will provide you with a receipt that you can submit for reimbursement after you have used your entire package. Upon request, we will also provide a receipt for visits used to date that you can, at your discretion and in accordance with your HRA or FSA rules, submit for reimbursement. Please note that HRA and FSA plans have rules about what services qualify for reimbursement. You are responsible for complying with your HRA and/or FSA plan rules when determining whether the services you purchase from qualify for reimbursement.

- **Cancellation policy.** We are committed to providing exceptional care. Unfortunately, if one client cancels without giving enough notice, they prevent another client from being seen during that time. Please call us at (585) 851-8259 by 2:00 PM on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel or change a Monday appointment, please call by 2:00 PM on Friday. If prior notice is not given, you will be charged $75.00 for the missed appointment.
- **Appeals Policy.** You understand that you are responsible for filing all appeals of adverse benefit determinations. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.

I HAVE READ, UNDERSTAND AND AGREE TO THESE PAYMENT TERMS.

Client Name:

____

____	____________________
Client Signature	Date

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Notice of Privacy Policy Acknowledgement

By signing here I acknowledge that Thrive Physical Therapy's Privacy Policy is available to me at www.thriveptandwellness.com/privacy-policy.

I also understand that a printed copy of the privacy policy is available to me at my request.

______________________________ ______________

Client Signature Date