



## NEW PATIENT CHECKLIST

If you need to see a physical therapist, you want to get the most out of each and every visit. Before you can show up for a visit, you want to make sure that you are well prepared. By calling your insurance company, finding the right practitioner and arriving early, you will be ready to begin at the very first appointment you make.

### ❖ Call Your Insurance Company

The customer service phone number should be on the back of your card. Ask about your physical therapy out-patient benefits. It may also be a good idea to see if you need a referral from your primary care physician before receiving treatment. Getting information like this in advance ensures that you will not receive any unexpected bills and will keep you informed of what your financial responsibilities are.

### ❖ Set Up An Appointment

Get out your planner or calendar to make it easier to choose days and times that work well for you. \* If you are seeking care because of an auto accident or work related incident please tell us right away. You will need to keep copies of all receipts and information that you are given and may be called upon to hand over copies of these papers to a lawyer or insurance agency, depending on the circumstances. It might be a good idea to create a folder or notebook to keep all of these things together and in order.

### ❖ Arrive Early

If you are a new patient, you will need to fill out paperwork. You can get most of it done ahead of time in the comfort of your own home by printing the patient registration and health history packets on our website. Be sure to have your insurance card handy so a photocopy can be made.

*When it comes to health care, you don't want to worry about the unknown at your first visit.*

*All advance preparation can help you feel comfortable and relaxed as you meet with a specialist and take the first steps to feeling better.*

### **PLEASE BRING THE FOLLOWING WITH YOU TO YOUR FIRST APPOINTMENT:**

- Your completed new patient forms
- The prescription from your Doctor and some insurance companies require a referral from your Primary Care Physician.
- Your Insurance Card
- Your Co-Pay or Payment- Payment is expected at the time services are rendered. We accept cash, check, Visa and MasterCard
- Any written reports of test results you may have had such as x-rays or MRI's.
- Please wear comfortable clothing, loose exercise-oriented clothing such as T-shirts, sweatpants and sneakers are recommended. If you are coming to us for a knee or lower extremity condition, please bring a pair of shorts or wear pants that are easy to roll up.

**HOUGHTON PHYSICAL THERAPY**

**PATIENT INFORMATION FORM**

**Please print and complete ALL items. If an item doesn't apply, put N/A**

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_  
Street City State Zip

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Your Employer Name and Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Your Email: \_\_\_\_\_

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*Referring Doctor:* \_\_\_\_\_ *Phone:* \_\_\_\_\_

*Address:* \_\_\_\_\_ *Next Dr. Appt:* \_\_\_\_\_

*Primary Care Doctor:* \_\_\_\_\_ *Phone:* \_\_\_\_\_

*Address:* \_\_\_\_\_ *Last Dr. Appt:* \_\_\_\_\_

**Person to notify in case of emergency:**

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Relation: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

**Who referred you to Houghton Physical Therapy?**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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**PRIMARY Insurance Company:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_

Policy Holder's Name: \_\_\_\_\_  
last first middle

DOB \_\_\_\_\_ Policy #: \_\_\_\_\_ Group#: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Policy Holder's Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
Street City State Zip

Position: \_\_\_\_\_ Phone: \_\_\_\_\_

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**Is there Secondary Insurance?** Yes \_\_\_ No \_\_\_

Name of Secondary Insurance Company: \_\_\_\_\_

Policy #: \_\_\_\_\_ Group#: \_\_\_\_\_

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**IS THIS A WORKER'S COMPENSATION CLAIM?** Yes \_\_\_ No \_\_\_ Date of Injury: \_\_\_\_\_ Company: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Claim #: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Is there an attorney involved in your case? Yes \_\_\_\_ No \_\_\_\_

Attorney's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

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IS THIS AN ACCIDENT CASE? Yes \_\_\_ No \_\_\_ VEHICLE \_\_\_ OTHER \_\_\_\_\_ Date of accident or loss: \_\_\_\_\_

Insurance Company to Bill: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

Phone #: \_\_\_\_\_ Claim #: \_\_\_\_\_

Adjuster Name: \_\_\_\_\_

A. HOUGHTON PHYSICAL THERAPY AND SPORTS CONDITIONING NOTICE OF PRIVACY PRACTICES: At the time of my appointment I was offered a copy of the "NOTICE OF PRIVACY PRACTICES" (HIPAA) and also was given a copy to read explaining my privacy rights. \_\_\_\_\_ (initial)

I hereby authorize HOUGHTON PHYSICAL THERAPY, LLC. to furnish information to the insurance carriers concerning my treatment and hereby assign to the therapist(s) all payments for service rendered. I understand that I am responsible for all charges, even those not paid by my insurance. I understand that by signing I am giving my permission for treatment. I also authorize Houghton Physical Therapy, LLC. to contact the insurance commissioner on my behalf, to assist me in receiving my full insurance benefits, if deemed necessary.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Signature for Minor (under 18 years of age) \_\_\_\_\_

RECEPTIONIST INITIALS \_\_\_\_\_

**HOUGHTON PHYSICAL THERAPY  
FINANCIAL POLICY**

**TO OUR VALUED PATIENTS:**

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, **we need your assistance**, and your understanding of our payment policy.

Payment for services is due on each visit for charges incurred up through your last visit. We accept cash, checks, MasterCard, or Visa. We bill electronically, to expedite payment of claims.

**Please read carefully:**

1. Your insurance is a contract between you, your employer and your insurance co. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of U.C.R. "U.C.R." is defined as usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility.
4. **Medicare patients are responsible for the yearly deductible and if Medicare is the only insurance you are responsible for 20%.**
5. If this injury is work related, and a Workers Compensation claim has been initiated, you are given 10 visits with no claim number, if after the 10th visit, a claim number has not been received, or your case is denied by WC, then you are responsible for each additional visit. **We require, on your initial visit, that you provide us with your medical insurance to insure payment of the account if your case is not allowed. If you already have a claim number, please provide us with the number on the registration form.** If you have an attorney, please provide this information on the registration form.
6. For liability cases, where another party is responsible, you need to provide us with all the billing information. If you have an attorney, please provide this information on the registration form. It is this office's policy that a letter of protection, also known as a lien must be received from your attorney within the first 2 weeks of your treatment. Without this letter, you become responsible for the account in full.

Again, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. **We are here to help you!**

I have read the above policies and agree.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

# HOUGHTON PHYSICAL THERAPY AND SPORTS CONDITIONING

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**Orthopedic Therapy and Sports Conditioning Center**

## PATIENT MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well being and gain of your physical abilities is something every one in our clinic takes quite seriously.

Because we care so much about you we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do.

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we have certain rules that need to be followed in order to ensure the most optimum results.

We expect you to keep all your appointments. Write down the time of your visits so that you do not forget.

With the exception of serious emergencies it is expected that you keep all your appointments. If you need to re-schedule an appointment we require a 24 hours notice. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferably the very next day.

In an instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a \$25.00 fee \*\*.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

Todd A. Houghton  
CEO Houghton Physical Therapy and Sports Conditioning

I have read and understand this policy (signature):

\_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
Print name

\*\* (This \$25.00 charge will only be enforced if you are being treated under your Health Insurance Plan. If you are being seen through either a Workman's Compensation claim or a Motor Vehicle Accident we will contact your claims adjuster regarding your attendance history).