MEDICAL HISTORY QUESTIONNAIRE

Date_____ **Hand Dominance:** o Left o Right **Weight:** _____ **Height:** _____

Patient Name: _____ **SSN:** _____ **DOB:** _____

Email _____ Email Reminder o **Cell:** _____ Text Reminder o **Home:** _____ Call Reminder o

Employer : _____ **Job Title:** _____ **Working:** o Yes o No o Restricted/Light Duty

Primary Insurance: _____ **Secondary Insurance:** _____

Family Doctor: _____ **Family Doctor Group name:** _____ Send Notes o

Specialist Doctor: _____ **Specialist Group Name:** _____ Send Notes o

Referring Physician: _____ **Next Visit:** _____ **Group Name:** _____

SOCIAL HISTORY:

Attorney: o Yes oNo If Yes Name: _____

Cultural/Religious: Do you have any customs or religious beliefs or wishes that might affect care? _____

Work/School/Leisure: **o Working F/T** o Working P/T o Unemployed o Retired o Student

MEDICAL HISTORY:

Please check if you have ever had:

o Alzheimer's	o Broken Bones	o Osteoporosis	o Blood Disorders
o Heart Disease/Problems	o High Blood Pressure	o Parkinson's	o Lung Problems
o Stroke	o Cancer	o Rheumatoid Arthritis	o Infectious Disease
o Current Infection	o Low Immune Systems	o Tramatic Brain Injury	o Seizures/Epilepsy
o Diabetes Type 1	o Lupus	o Skin Disease	
o Diabetes Type 2	o Obesity	o Ulcers/Stomach Problems	
o Fibromyalgia	o Other: _____		

Have you ever had surgery: o No o Yes If yes, please describe and include dates:

_____ Date: _____

_____ Date: _____

_____ Date: _____

Have you received physical therapy in the past 12 months? o Yes o No If Yes for What: _____

GENERAL HEALTH:

Please Rate your Health : o Good o Fair o Poor o Other: _____

Do you exercise beyond normal daily activities and chores? o Yes o No If yes, describe the exercise: _____

_____

CURRENT ISSUE OR PROBLEMS:

Describe the problem(s) for which you seek physical therapy: _____

_____

When did the current problem(s) begin? Date: _____ Have you had this problem before? o Yes o No

MEDICATIONS/VITAMINS/SUPPLEMENTS:

Do you take any prescriptions or over the counter medications/vitamins/supplements? o Yes o No

If yes, please list: _____

FPTI dba Accelerate Therapy & Performance may release all Medical information to: _____

Patient Signature: _____

ACCELERATE
THERAPY & PERFORMANCE

Missed Visit Policy

At Accelerate Therapy & Performance, our goal is to help all patients reach a fully recovered state. Your physical therapist will provide you with your plan for care during the evaluation appointment and will inform you of the required number of visits to help you achieve your goals. Patients who attend all of their physical therapy visits are 93% more likely to fully recover from an injury whereas those that miss even one visit have a lower potential for recovery. We are happy to share a copy of this study with you but want to make sure that you understand that it is extremely important that you attend all of the appointments. This policy ensures that all patients have the opportunity to receive the care they need.

Please read our policy and sign at the bottom indicating you understand our expectations and our policy.

1. As experts, we know that **you will not reach full recovery if you do not attend your appointments**. To help ensure you have the best chance at recovery, we will work with you to schedule out all of your appointments after your evaluation today and in order to have the best chance at recovery, you will need to attend each visit.
2. Please note: Our goal is to begin your treatment sessions on schedule. For all appointments after your evaluation, we expect that you will arrive at least 5 minutes prior to your appointment time, dressed for your session, and ready to begin on time. This will allow our front office to handle their responsibilities and our specialists to provide the care you need and deserve.
3. If you're late for your appointment, you're missing the time that we have specifically scheduled for your care and we cannot guarantee that we will be able to provide you with your full treatment as we have reserved the appointment time following yours for someone else.
4. If you're running late, we need you to call us immediately so we can prepare for your late arrival and consult with your clinician. If you are more than 5 minutes late, your session may need to be rescheduled and if that occurs, you will incur a missed visit charge. Chronically late patients will be asked to change their appointment times.
5. While we understand that illness can strike at any time, we still expect that you will work to provide at least a day's notice if you cannot attend a scheduled appointment.
6. Providing care to all patients is extremely important to us and late notice of changes or cancellations will keep someone else from getting the care they need and deserve. **If you need to cancel or change a scheduled appointment, for any reason, we require you to contact us by closing the business day before, so we have enough time to help another patient who needs to get in for the care they need and deserve.**
7. When you call to cancel an appointment, have your schedule ready as we will reschedule you right away.
8. **We reserve the right to charge a missed visit fee of $50.00 if you do not provide at least a days' notice of your appointment change or cancellation and will comply with payer policy in carrying it out**
9. **To avoid our missed visit fee, we need you to call our office during business hours -to avoid issues with our policy.**
10. Patients who have multiple same-day cancellations or no-shows, will be removed from the active schedule and will be placed on the day-to-day list to avoid future missed visit charges. We will also notify your physician of your non-compliance.
11. If you're a worker's comp patient, we are required to notify your claims adjuster if you cancel or no-show for an appointment.

We look forward to working with you to meet your physical therapy goals. To avoid any issues with our policy, we only need the required notice, so we have enough time to help all patients to get in for the care they need and deserve.

Delaine Fowler, Owner

This policy has been reviewed with me and by signing below I am indicating that I understand and this policy.

Patient Signature	Patient Name	Date

Attendance Policy, Consent to Treat & HIPAA

Accelerate Therapy and Performance strives to provide each patient with the highest quality care while accommodating patient schedules. We reserve time slots for each patient in order to minimize waiting time and assure continuity of care. Your consistent attendance of the planned treatment regimen is paramount to your full recovery!

Consent to Treat

I give permission for Accelerate Therapy and Performance to provide the medical treatment appropriate and necessary for the rehabilitation of my or my dependant's current physical condition.

Privacy

Accelerate Therapy and Performance understands that you have read and are aware of the current rules and regulations regarding Patient Rights and Responsibilities. HIPPA policies are posted in the front office of this clinic, and are available upon request in print form. Any changes to the HIPAA Privacy Act, effective April 14, 2003, or patient rights will be posted in our office lobby. Copies are available.

I agree to and understand the above policies:

_____ _____

Patient/Guardian/Guarantor of Payment Signature Date

_____ _____

Facility Representative/Witness Date

Payment Policy and Financial Agreement

Thank you for choosing Accelerate Therapy and Performance for your Physical Therapy needs. This financial agreement describes both patient and insurance responsibility for services rendered. Please read this agreement, ask us any questions you may have and sign in the space provided.

Insurance

Your insurance coverage is a contract between you and the insurance company and we are not a party to that contract. We must emphasize that as medical care providers, our relationship is with you, not your insurance company. It is also your responsibility to know your insurance benefits including referrals, pre-certifications and required authorizations. As a courtesy we will submit your claims to your primary and secondary insurance companies however we do expect payment for all services within 60 days. It may become necessary for you to pay your account in full if your insurance fails to do so within 60 days. If we are given incorrect or incomplete insurance information you will be billed and payment will be expected within 30 days, unless the issue is resolved.

Notice of Medical Record Release

Medical records are the property of the payer of service, in most cases the insurance company. We can print medical records for patients to have for a records fee of $15.

Patient Responsibility & Payment and Refund

Payment of copays and deductibles will be due at time of service. Collection is required by your insurance companies for these amounts. You are ultimately responsible if your insurance denies a claim for any reason. If you do not have insurance payment in full will be due at time of service. The amount of your bill is expected to be paid in full within 30 days of the date on the statement, unless payment arrangements have been made with the Billing and Accounts Manager, or Billing Coordinator. Anything over 30 days is considered past due. Refund/Return Policy on Services: All sales on services provided are final. This includes package deals for discounted services. All packaged/discounted treatment plans are final but there is no expiration on the purchased sessions. All packages are allowed for one time exchange of unused portion toward other purchased services at our clinic.

Payment Options – Credit Card on File

For your security and protection, Accelerate Therapy and Performance stores your encrypted and tokenized credit card data in an off-site, secure vault that exceeds all HIPAA and PCI Data Security Standards.

I authorize Accelerate Therapy and Performance to automatically debit the card on file for any patient responsibility, including standard co-pays, remaining balance, payment plans and no-show fees.

I understand that I can update my card information on file at any time by contacting our office directly. In fact, it is my responsibility to notify Accelerate Therapy and Performance of any updates or changes to the credit card on file associated with this agreement as soon as possible.

Credit Card Information

Card Type: Visa Mastercard American Express Discover

Name on Card: _____

Credit Card Number:_____ CVV:_____

Exp (MM/YY):_____ Billing Zip Code:_____

Non-Payment

Failure to pay will result in your account being referred to a collection agency, which will affect your credit. NSF checks will result in a $25.00 returned check fee.

I have received this financial policy, and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts will be referred to a collection agency. If it becomes necessary to send my account to a collection service, You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

_____	_____	_____
Patient Signature	Printed Name	Date
_____	_____	_____
Parent/Guardian Signature	Printed Name	Date

ACCELERATE
THERAPY & PERFORMANCE

Authorization to Use Name and Likeness in Marketing Video, In Print and On-Line

I, _____, a patient of Fowler Physical Therapy dba Accelerate Therapy & Performance ("FPTI DBA ATP"), understand that:

A. FPTI DBA ATP is preparing marketing materials (videos, newsletters, newspaper inserts, on-line, social media) which will demonstrate the success and results of the physical therapy it provides;
B. FPTI DBA ATP will provide copies of the material to potential referring Physicians, as well as to individuals who are potential patients;
C. In order to create the materials and show the results obtained by FPTI DBA ATP patients, it is necessary for FPTI DBA ATP to take pictures and video/audio recordings of patients prior to, during and following the treatments they receive at FPTI DBA ATP;
D. I have been asked and agree to appear in the materials;
E. Therefore, FPTI DBA ATP will take pictures and video/audio recordings of me prior to, during and after the treatment I receive from FPTI DBA ATP;
F. FPTI DBA ATP will incorporate the pictures and video/audio recordings stated above into the materials;
G. My likeness and/or name will appear in the materials;
H. The condition for which I am being treated at FPTI DBA ATP may be expressly stated in the materials;

I hereby authorize FPTI DBA ATP, its employees, agents, officers and directors to photograph, film, videotape, record and/or portray my name, likeness, voice and/or actions prior to, during and after the treatment I receive at FPTI DBA ATP and incorporate the same into the materials which are to be used for marketing purposes. I also authorize FPTI DBA ATP to incorporate my diagnosis into the materials, along with such other information, as FPTI DBA ATP deems appropriate. I waive any rights I may have to inspect or approve the incorporation of the pictures and video/audio recordings of me into this material. I understand that all rights in and to the above authorized material, including copyright, shall be FPTI DBA ATP's sole and absolute property.

I understand FPTI DBA ATP cannot control the further dissemination of the materials after they leave the control of FPTI DBA ATP. Accordingly, I release FPTI DBA ATP from any liability related to the dissemination of the materials.

I understand that I can revoke this Authorization at any time. My revocation must be in writing and sent via certified mail to Fowler Physical Therapy dba Accelerate Therapy & Performance, Inc., 1508 West Innes St. Salisbury NC 28144. However, FPTI DBA ATP will still be authorized to distribute any copies of the material that has been produced through the end of the day on which FPTI DBA ATP receives my revocation.

I agree that I have read and understand this Authorization and am at least eighteen years of age and intending to be legally bound hereby, I set my hand and seals on the date below written.

Witness: _____

Date: _____

Signature: _____

Date: _____

☐ I wish to OPT OUT of this program. Signature: _____ Date: _____