Huxley
Physical Therapy

Rob Drew, PT, LAT
Physical Therapist/Athletic Trainer
Owner

Patient Guidelines

Scheduling

- In order to receive maximum benefit from your rehabilitation program, it is of utmost importance that you attend your therapy appointments and be compliant with your home exercise program.
- Please be aware that your appointments may generally be on any day of the week and do not have to be set up in a specific pattern. For example, if you are to receive treatment three times weekly, the appointments do not have to be scheduled on Monday, Wednesday, and Friday.
- We request that if you are unable to keep your appointment that you notify us 24 hours (or as soon as reasonable possible) prior to your scheduled appointment. You are subject to be discharged from our services after three missed appointments (within a four week period).
- We try to do our best to accommodate your busy schedule and do offer extended hours for this reason. If the time of day or days of week that you are able to attend therapy is very limited, it is recommended that you schedule your appointments more than a week at a time so that we may try and accommodate your schedule.

Physician Follow up Visits

- If you do have follow up visits scheduled with your physician in regard to your physical therapy rehabilitation, please let us know the dates so we may communicate your progress in therapy with your physician.

Insurance

- We do verify benefits for physical therapy for all insurances and it is recommended that you do the same. Please check with us after your first visit to verify/confirm your insurance benefits for physical therapy.
- Your insurance will be billed at the end of each month. You will receive a monthly statement from our billing agent. If your insurance benefit requires a co-pay, we would appreciate payment at the time of service or weekly while you're attending therapy. **Outstanding balances past 120 days will automatically be turned over to collections.** If you have any questions about billing or payments, we are happy to help you as is our billing agent.

Your cooperation is appreciated. We look forward to working with you and obtaining optimum outcomes from your rehabilitation program. This form has been fully explained to you and you understand it.

Patient signature_____ Date _____

408 Campus Dr. Ste B. Huxley IA 50124, Mailing Address PO. Box 208 Tele (515) 597-3726 Fax (515) 597-3727 Pager/Cell (515) 577-0218 E-Mail huxleypt@huxcomm.net

Huxley Physical Therapy
Patient Information Sheet

First Name_____ MI_____ Last Name_____
Address_____
City_____ State_____ Zip_____
Gender: M F Birth Date_____ Age_____
Social Security #_____Email_____
Referring Physician_____
Home Phone_____ Work Phone_____Cell Phone_____

Emergency Contact_____ Phone_____
Responsible Party/Insured_____Birth Date_____
Relationship to Insured Self_____ Spouse_____ Child_____ Other_____

Employer Name_____
Employer Address_____
City_____ State_____ Zip_____
Occupation/Job Title_____
Work or Auto Injury _____ Where injury occurred_____
_____Date injured _____
Supervisor_____ Case Manager_____

(Please provide a copy of your insurance card to verify the information listed below.)

Primary Insurance_____ Policy # _____
Address_____
City_____ State_____ Zip_____
Telephone_____

Secondary Insurance_____ Policy #_____
Address_____
City_____ State_____ Zip _____
Telephone_____
Responsible Party/Insured_____
Relationship to Insured Self_____ Spouse_____ Child_____ Other_____

Office Use Only
Insurance Benefits: Effective Date:_____
Coinsurance %_____ Deductible $_____ Met $_____
Copay $_____
Pre-cert Required? Yes No #_____ # of visits allowed_____
Visits allowed/year_____ Visits used_____
Is any of the following required with the claim?
Letter of medical necessity_____ Prescription_____ Medical Records_____
Spoke to:_____ Date_____
Medical Record #_____

Huxley Physical Therapy
Consent for Care

Consent to Treatment: I consent to rehabilitation and incidental medical services at Huxley Physical Therapy.

Liability: I understand that Huxley Physical Therapy is not responsible for loss or damage to personal valuables.

Release of Information: I allow Huxley Physical Therapy to give information related to me to any third party payer or insurance company, which may be responsible in whole or part for paying my bill and to any health care facility or physician by which I am referred.

Authorization of Payment: I hereby assign all benefits directly to Huxley Physical Therapy. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment. In the event that any supply costs are denied by the insurance, the patient will pay for the supply(s) in full. ***Outstanding balances past 120 days will automatically be turned over to collections.***

I have read and understand the above

_____

Patient's Signature Date

_____

Witness Signature Date

(If the patient is a minor, or legally incapacitated, please obtain the signature of a parent or guardian)

Acknowledgement of Notice of Privacy

Huxley Physical Therapy
408 Campus Dr., Suite B
PO Box 298
Huxley, IA 50124

I acknowledge that I received Huxley Physical Therapy's Notice of Privacy Practices. My signature below indicates that I have received a copy of the Notice of Privacy Practices for Huxley Physical Therapy, effective April 2003.

Signature: _____ Date: _____

Print Name:_____ Telephone:_____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Personal representative of patient unable to sign

Name of Patient:_____

For office Use Only:

- ☐ *Signed form received by:*_____ *Date:*_____

- ☐ *Acknowledgement refused:*

Efforts to obtain:

_____

_____

Reasons for refusal:

_____

_____

Huxley Physical Therapy

Medical History

Place a check beside all that pertain to your medical history:

____ Heart Disease (heart attack, bypass surgery, etc.)
____ Pacemaker
____ High blood pressure or low blood pressure
____ Cancer_____
____ Diabetes
____ Asthma or other lung conditions_____
____ Headaches
____ Metal Implants (total hip or knee replacement)
____ Arthritis
____ Allergies_____
____ Tobacco user (smoke or chew)
____ Pregnant or think you may be

List the medications you are taking:_____
_____
_____

List any surgeries in the past 5-10 years:_____
_____
_____

List any special tests you have had (MRI, CT scan, etc.):_____
_____
_____

Any other forms of treatment you have tried:_____
_____

Do you feel you need assistance from Social Services? □Yes □No

Anything else you feel the therapist should know about your medical history:_____
_____
_____
_____

_____
Signature Date