

ATTENDANCE POLICY



FASTTRACK

FITNESS & PHYSICAL THERAPY

39815 Alta Murrieta Drive; Ste. C-1
Murrieta, CA 92563

Ph: (951) 304-7673

Fax: (951) 304-7680

In order to receive the most benefit from rehabilitation, it is important that you follow the treatment plan prescribed by your physician and therapist and attend all sessions on a regular basis.

We ask that you give us at least 24 hours notice if you must cancel your appointment. Cancellations made with less than 24 hours notice and/or missed appointments will result in a \$25 (twenty-five dollar) charge which will be billed directly to you. Insurance companies will not cover missed appointment charges.

We appreciate your cooperation and thank you in advance for understanding.

The above information has been read by and explained to me. **I understand my responsibility for the payment of any charges for cancelled or missed appointments.**

Client/Guardian: _____ Date: _____

Fast Track Witness: _____ Date: _____

Medical Billing Explained

At Fast Track Fitness and Physical Therapy, we know that many people do not know how their insurance works. As a courtesy to you, we provide this sheet to help you better understand how our services are billed. This sheet is not designed as a definitive guide to your benefits but is instead designed as a general outline. **It is your responsibility to contact your insurance company for an explanation of your benefits.**

Medicare - Medicare will pay for 80% of the allowed amount of your bill. If you have a supplemental insurance, this will usually cover the remaining portion of the bill. If you have a secondary insurance plan; reimbursement will vary. Some plans will pay the remaining amount, some plans will pay 80%, and others will not pay any of the remaining amount. If you do not have a supplemental or secondary insurance, you will be billed for the remaining 20%.

Workers Compensation - Workers compensation will pay 100% of all authorized visits. Any appointments missed, without prior notification, will be billed to the patient.

Private Insurance - Private insurance is more complicated. Below we have outlined the main features of private insurance.

Deductable - This is the amount of money that you must pay out-of-pocket before your insurance company will begin to pay out benefits. If you have not yet met your deductible amount for the year, then you will be responsible for the full amount of the physical therapy services provided until you reach the set deductible amount.

Co-insurance - This is the percentage that the insurance company and you will pay following your fulfillment of your deductible. This percentage will be in force until you reach a maximum out-of-pocket expense. This percentage ratio is typically 90/10, 80/20 or 70/30. This means that you will be responsible for 10, 20, or 30% of the bill depending on your plan. Most insurance plans have a maximum out-of-pocket expense. Once this has been fulfilled, many insurance plans will pay the bills in full.

Co-pay - this is the amount that is due at the time of an office visit. This amount will often fulfill the above defined coinsurance requirement.

Cancellation/No-Show Fees - these are always the patient's responsibility and will be billed as such. Each occurrence will result in a \$25 charge.

Physical Therapy Charges - Physical therapy charges vary little from provider to provider. In-network providers must sign and accept contracted rates set by the insurance companies.

Patient Signature

Date

Disclosure of Information



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AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Specific description of information that may be used disclosed:
 - All individually identifiable health information in the patient's medical record.
2. The information will be used/disclosed for the following purpose(s):
 - To provide appropriate treatment
 - To bill appropriate carrier
 - To share information with referring physician
3. Persons/organizations authorized to use or disclose the information:
 - *Fast Track Fitness and Physical Therapy*
4. Persons/organizations authorized to receive the information:
 - Referring physician
 - Billing company
 - Other _____
5. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, the facility reserves the right to deny that health care.
6. I understand that I may inspect or copy the information used or disclosed.
7. I understand that I may revoke this authorization at any time by notifying the facility in writing, except to the extent that action has been taken in reliance on this authorization.
8. I understand I have a right to request/receive a Notice of Privacy Practices from the facility.

Signature of patient or patient's representative

Printed name of patient or patient's representative

Date

Relationship to patient, or representative's authority to act for the patient, if applicable

Intake Form



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Welcome to our clinic. In order to serve you properly, we will need the following information. (Please Print)

All information will be strictly confidential.

Patient's Name		Sex <input type="radio"/> M <input type="radio"/> F	Birth Date _____ Age _____	Marital Status Single <input type="radio"/> Married <input type="radio"/> Widowed <input type="radio"/> Divorced <input type="radio"/>	
E-mail					
Residence Address	City	State	Zip	Home Phone	Patient's Social Security #
Person Financially Responsible for This Account		<input type="radio"/> Self <input type="radio"/> Spouse	Responsible Party's Birthdate _____	Responsible Party's Social Security #	
Responsible Party Driver's License #	State	Number	Occupation	How Long at Current Employer?	
Name of Employer	Address	or <input type="radio"/> Not Applicable		Business Phone	Occupation
Reason for Visit			Referred by (include phone number)		
Person to Contact in Case of Emergency			Relationship to Patient	Phone	
Medicare <input type="radio"/> Yes <input type="radio"/> No Medicare No.			Medicaid <input type="radio"/> Yes <input type="radio"/> No Medicaid No.		
Medicare Secondary Insurance Name			Address	Policy #	Group #
Worker's Compensation? <input type="radio"/> Yes <input type="radio"/> No	Motor Vehicle? <input type="radio"/> Yes <input type="radio"/> No	Date of Accident	Treatment Authorized by	Claim #	W/C or MVA Insurance Phone #
Primary Insurance Company			Address	Is Insurance Through Your Employer? <input type="radio"/> Yes <input type="radio"/> No	
Subscriber Name		Subscriber Birth Date	Policy #	Group #	
Secondary Insurance Name			Address	Policy #	Group #

LIFETIME ASSIGNMENT OF BENEFITS/INFORMATION RELEASE/AUTHORIZATION TO TREAT:

I authorize payment of medical benefits to Fast Track Fitness and Physical Therapy for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release to my insurance company or its agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

I also authorize the Interdisciplinary Team to perform the treatments or procedures approved by my referring physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

I also authorize the release of test data and billing information to a licensed physician of the facility's choosing for the purposes of professional interpretation and establishment of a diagnosis and treatment recommendations.

I have received a copy of my Patient Rights and Responsibilities

Patient, Parent or Guardian Signature (if child is under 18 years old)

Date

Medical History Questionnaire



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The purpose of this questionnaire is to help us understand your health status. Please complete this form and your therapist will answer any questions during your exam. This form is considered part of your medical record.

Name _____ DOB _____ Age _____

Referring Physician _____ Family Physician _____

Date of Last General Health Check-Up _____ Occupation _____

Last Date Worked Due to This Injury _____

Date Returned to Work After This Injury _____

Have you had surgery for this injury? Yes No Type of surgery/Date _____

Is an Attorney involved in this case? Yes No Attorney Name _____

Pain (please draw a vertical line where you would rate your pain intensity) 0 5 10
(0 = no pain; 10 = maximum pain tolerable)

My pain can be described as (please circle all those that apply)

Constant Intermittent Sharp Dull Aching Stabbing Numbness Pins/Needles

Are you currently taking any prescription or non-prescription medications? Yes No

Anti-Inflammatories Muscle Relaxers Pain Medicines Other

Have you had any of the following Medical or Rehabilitation Care for this injury/episode? If yes, when?

	Yes	No	When	Yes	No	When
Chiropractor	<input type="checkbox"/>	<input type="checkbox"/>		CT Scan	<input type="checkbox"/>	<input type="checkbox"/>
General Practitioner	<input type="checkbox"/>	<input type="checkbox"/>		EMG/NCV	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>		MRI	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>		Myclogram	<input type="checkbox"/>	<input type="checkbox"/>
Massage Therapy	<input type="checkbox"/>	<input type="checkbox"/>		X-Rays	<input type="checkbox"/>	<input type="checkbox"/>
Neurologist	<input type="checkbox"/>	<input type="checkbox"/>		Emergency Room Care	<input type="checkbox"/>	<input type="checkbox"/>
Orthopedist	<input type="checkbox"/>	<input type="checkbox"/>		Podiatrist	<input type="checkbox"/>	<input type="checkbox"/>

Do you have or have you had any of the following?

	Yes	No	Yes	No
Asthma, Bronchitis, or Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Severe or Frequent Headaches	<input type="checkbox"/>
Shortness of Breath/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Vision or Hearing Difficulty	<input type="checkbox"/>
Coronary Heart Disease or Angina	<input type="checkbox"/>	<input type="checkbox"/>	Numbness or Tingling	<input type="checkbox"/>
Do you have a pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or Fainting	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>
Heart Attack / Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Weight Loss/Energy	<input type="checkbox"/>
Blood Clot / Emboli	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>
Stroke / TIA	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy Seizures	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Trouble / Goiter	<input type="checkbox"/>
Pins or Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence	<input type="checkbox"/>
Joint Replacement (any joint)	<input type="checkbox"/>	<input type="checkbox"/>	Bowel or Bladder Problems	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Neck Injury/Surgery	<input type="checkbox"/>
Infectious Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder Injury/Surgery	<input type="checkbox"/>
Cancer/Chemotherapy/Radiation	<input type="checkbox"/>	<input type="checkbox"/>	Back Injury/Surgery	<input type="checkbox"/>
Arthritis/Swollen Joints	<input type="checkbox"/>	<input type="checkbox"/>	Knee Injury/Surgery	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Leg/Ankle/Foot Injury/Surgery	<input type="checkbox"/>
Sleeping Problems/Difficulty	<input type="checkbox"/>	<input type="checkbox"/>	Elbow/Hand Injury/Surgery	<input type="checkbox"/>
Do you Smoke?	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis/Parkinson's	<input type="checkbox"/>

	Yes	No	Yes	No
FOR WOMEN ONLY				
Pelvic inflammatory disease	<input type="checkbox"/>	<input type="checkbox"/>	Endometriosis	<input type="checkbox"/>
Irregular menstrual cycle	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence (urinary/fecal)	<input type="checkbox"/>
Complicated pregnancies/deliveries	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant?	<input type="checkbox"/>

Patient/Guardian Signature _____ Date _____

PT Initials _____ Date _____

Summary of Patients' Rights and Responsibilities



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We are committed to serving you with compassion, care, skill, and respect. As one of our patients, you have choices, rights and responsibilities.

You have the **RIGHT**:

- To be treated with dignity and respect;
- To know the names and professional status of people serving you;
- To privacy;
- To confidentiality of your records;
- To receive accurate information about your health-related concerns;
- To know the effectiveness, possible side effects and problems of all forms of treatment;
- To participate in choosing a form of treatment;
- To receive education and counseling;
- To consent to, or refuse any care or treatment;
- To select and/or change your health care provider;
- To review your medical records with a clinician;
- To amend your medical records; and,
- To information about services and any related costs.

You also have the **RESPONSIBILITY**:

- To seek medical attention promptly;
- To be honest about your medical history;
- To ask about anything you do not understand;
- To follow health advice and medical instructions;
- To report any significant changes in symptoms or failure to improve;
- To respect clinic policies;
- To keep appointments or cancel in advance;
- To seek non-emergency care during regular business hours; and,
- To provide useful feedback about services and policies.

Signature

Date

PAYMENT POLICY



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PAYMENT POLICY FORM

Primary Insurance

We will bill your primary insurance as a courtesy to you. We assume payment of insurance benefits is not forthcoming on charges older than 60 days. Charges outstanding for more than sixty days will be due in full from you regardless of the type of insurance involved. Any remaining balance after your co-pay and your primary coverage has been paid, including items classified as "above usual and customary," is due from you upon receipt of the explanation of benefits from your primary insurance carrier. You will be responsible for any item not paid in full by your insurance carrier. Prior to beginning treatment, we will verify your insurance benefits. While we will take all reasonable action to provide accurate therapy benefit information for your specific plan, be aware that verification of benefits is not a guarantee of payment from your insurance carrier. **Secondary insurance will be your responsibility to file and collect.**

Medicare

We will bill Medicare for you. In most cases, Medicare will pay 80% of allowable charges. We will bill your secondary insurance for you, if you have one, or the balance will be billed to you.

Self Pay

Please pay the balance in full at the time of service or upon the receipt of a monthly statement or notice. In the event you are unable to pay the balance in full, we are willing to make reasonable payment arrangements. Please be advised that **Fast Track Fitness and Physical Therapy** is not a credit grantor, and therefore, failure to maintain these arrangements may result in the placement of your account with a collection agency or attorney for collection. Credit cards (Mastercard and Visa) are accepted for payment on account.

Workers' Comp

We will bill your Workers' Comp carrier for your charges. Please note that you will remain financially responsible for all of your charges if your carrier denies coverage.

Legal Suit

We will accept a legal letter of protection if you meet each of the following criteria:

1. Do not qualify for benefits under any insurance policy (medical or auto), and
2. Are indigent and cannot pay for charges due using cash or credit card, and
3. Are awaiting settlement and subsequent payment of damages from a related legal case, and
4. Return our lien, signed by both you and your attorney.

Prior to your settlement, payment on your account will not be required unless your charges remain outstanding for more than 90 days from the date of last treatment. Upon settlement of your legal case, your balance in full is due within 30 days. Please be aware that you will remain financially responsible for services rendered regardless of the payment option selected above. In the event your account becomes delinquent and is therefore in default of payment, the patient, legal guardian, or admitting parent will be responsible for the principal amount owing, and all reasonable costs associated with the collection of this debt, including, but not limited to, collection service fees, attorney's fees, and all court costs and additional legal expenses associated with the recovery of this debt. We reserve the right to charge interest on balances over 30 days old, charge returned check fees as allowed by state law, and charge a no-show fee for missed appointments when adequate notice of cancellation is not provided. Thank you for allowing us the opportunity to serve you. If you have any questions about the above information or any uncertainty regarding your insurance coverage, please ask for our assistance. Kindly sign and date this document to indicate that you understand and agree to the terms of this payment policy.

Cancellation Policy

To maintain appointment times available for all of our patients, there is a charge of \$25.00, *BILLED TO THE PATIENT*, for each instance a patient does not show for a schedule appointment or does not give at least 24-hour cancellation notice.

- Checking this box indicates that the formal office **HIPAA policy and procedures** have been explained to the above-noted patient and that a copy of the policy was provided to the patient.

Assignment of benefits/authorization to release medical information/consent to treatment: I hereby assign all medical benefits to which I am entitled to **Fast Track Fitness and Physical Therapy**, in the event they file insurance on my behalf, I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is there in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 1.5% per month (12% annually) for unpaid balances over 30 days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of **Fast Track Fitness and Physical Therapy** as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

AUTHORIZED SIGNATURE

DATE