GAME CHANGER
PHYSICAL THERAPY

PATIENT INFORMATION:

Patient Name:_____Gender:_____Date of Birth:_____Age:_____

Address: _____City: _____State:_____Zip code:_____

Phone: _____ Email: _____

Occupation: _____ Employer/School: _____

Phone: _____ E-mail: _____

Referring Physician: _____ Phone:_____ Fax: _____

Primary Care Physician: _____ PCP Phone: _____

EMERGENCY CONTACT (Parent/Guardian if patient is a minor):

Name:_____ Phone: _____ Relationship: _____

INSURANCE:

Primary Insurance Company:_____

Regarding Insurance:

- Game Changer Physical Therapy is a fee-for-service business and does not bill health insurance. This information is only collected so that we can help you in navigating the process of getting reimbursed for out-of-network services.
- If you use Medicare services, you will not be able to submit for reimbursement by Medicare.
- The state of AZ allows Direct Access to physical therapy. This means you can receive physical therapy treatment without a physician referral. However, some insurances REQUIRE a physician referral for reimbursement. If you would like to submit a SuperBill to your insurance, **it is your responsibility to contact your insurance provider to determine if a prescription is needed**.
- **It is your responsibility to understand your insurance benefits**. Please utilize the provided "How to Determine Your Insurance Benefits for Physical Therapy" when you contact your insurance provider to determine if a referral or pre-authorization is required prior to receiving care. Please be aware of expectations for your out-of-network benefits.

By signing below, I understand the above statement regarding insurance.

Patient Name: _____ Date:_____

Patient Signature:_____

REASON FOR PHYSICAL THERAPY VISIT:

Issue(s) you are here to address: _____ Date of onset: _____

Rate your pain (0-10) using the following scale: *0 = no pain, 10 = you have to go to the hospital*

Pain at rest: _____ Pain with most aggravating activity: _____

What makes your pain worse:_____ What makes your pain better: _____

Is your pain worse in the A.M. / P.M?

DESCRIBE SYMPTOMS: ***Please mark all that apply***

Burning	Sharp	Dull/Ache	Throbbing	Numbness	Shooting	Tingling
Full	Tight/stiff	Constant	Intermittent	Vague	Other: _____	

Other notes about your symptoms: _____

Since the onset of your symptoms, do you have any pain or difficulties with the following?

Bending	Carrying	Coughing	Lying down	Lifting	Pulling	Pushing
Self care	Sit to Stand	Sitting	Sleeping	Sneezing	Sports/Fitness	Standing
Stairs	Squatting	Travel	Reaching	Running	Walking	Work tasks

Other: _____

DIAGNOSTIC TESTING:

X-ray - CT Scan – MRI - EMG - PET Scan - Ultrasound − Other:
_____

Specific findings/Results:_____

SURGICAL HISTORY

Surgeries Performed, including date: _____

_____

MEDICAL HISTORY

Height: _____ Weight: _____ Do you smoke: Yes/No

Any History of Falls? Yes/No If Yes, when was your last fall and what happened? _____

Previous therapy or body work:_____

Current medications/vitamins/supplements (include dosage and reason for taking): _____

_____

Hours of sleep per night on average: _____ Stress level on average: _____ Dietary habits:_____

Please mark all that apply and give explanation below:

Allergies	Anxiety	Arthritis	Asthma	Bipolar	Bowel/Bladder changes
Cancer	Cardiovascular disease	Child births/ Pregnancies	Depression	Diabetes	Difficulty speaking
Difficulty swallowing	Dizzy spells	Fractures	Headaches	High/low blood pressure	Hearing impairment
High cholesterol	HIV+/AIDS	Joint replacement	Lung disease	Motor Vehicle Accidents	Multiple Sclerosis
Nausea	Night pain	Osteoporosis/ osteopenia	Pain with intercourse	Pain with toileting	Rheumatoid disease
Seizures	Shortness of breath	Stroke	Thyroid dysfunction	Unexplained weight loss/gain	Vision problems

Other: _____

Explanation of conditions marked above: _____

The Patient-Specific Functional Scale

Please identify 3 important activities that you are unable to do or are having difficulty with as a result of your condition. Then rate each activity 0-10.

0= unable to perform 10= no difficulty with activity

Activity	Score
1.	
2.	
3.	

What would you like to accomplish through therapy? i.e. Goals:_____

_____

Print name: _____

Sign name: _____ Date: _____

GAME CHANGER
PHYSICAL THERAPY

PATIENT INFORMATION and FINANCIAL POLICY
PLEASE FILL OUT and BRING WITH YOU to your first appointment.

Natalie Jones, PT, DPT is an out-of-network provider for insurance companies. Instead, Game Changer Physical Therapy, LLC is a cash-based practice. By not having a preferred provider/contracted status with the insurance companies, the therapist does not have to limit the time or quality of treatment provided secondary to insurance company restrictions or elevate clinic rate to pay for billing services.

Prior to your first appointment, you may call your insurance company to completely understand your physical therapy benefits. You may refer to the Insurance Benefits and Questions Worksheet (on our website and included in this packet) to help you ask the insurance company the right questions about your physical therapy benefits. At the time of service and payment, you may request a written statement and bill which you can submit to your insurance company for their consideration of reimbursement to you. The amount of reimbursement you receive will vary according to the terms of your insurance policy. Some companies may reimburse at 80%, some at 60%, some at 40%, and some may not reimburse at all. Game Changer Physical Therapy cannot make guarantees or estimates regarding what reimbursement your plan allows.

Medicare Patients: Game Changer Physical Therapy does **NOT** accept Medicare Insurance and patients cannot be reimbursed by Medicare for visits at this clinic.

Game Changer Physical Therapy, LLC accepts cash, check, or credit card **at the time of service**. Rates are based on time spent with you and the treatments performed during your appointment. The rates are as follows:

$175 for Initial Evaluation/Follow-ups
$90 for 30 minute massage

**Package offers available at discounted price*

CANCELLATION / NO SHOW POLICY We are entering into a cooperative partnership to help you attain your maximal physical therapy goals. It is understandable that circumstances may arise which cause you to cancel your appointment. However, cancellations have a serious impact on the clinic. Cancellations more than 24 hours in advance will not be charged. Cancellations less than 24 hours in advance will pay a cancellation fee of $50. If you need to cancel a Monday appointment, you must notify the clinic by 4:00pm on Friday to avoid the cancellation fee. Cancellations within 2 hours of your scheduled appointment time will be charged for the full amount of your scheduled appointment. By signing this document I agree to these conditions:

_____ _____
Patient Signature Date

_____
Printed Name

GAME CHANGER PHYSICAL THERAPY, LLC

Health Insurance Portability and Accountability Act (HIPAA): Notice of Privacy Practices for Personal Health Information

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Dear Game Changer Physical Therapy Patient:

This is your Health Information Privacy Notice from Game Changer Physical Therapy. You are receiving this Notice as mandated by law to inform you of the policies and procedures employed by this clinic and its staff in order to ensure the privacy of your Personal Health Information (PHI). This Notice also describes your rights with respect to your PHI and how you can exercise those rights. PHI includes individually identifiable health information in any form, including information transmitted orally, or in written or electronic form.

We are required by law to:

1. Notify patients about their privacy rights and how their PHI can be used.
2. Adopt and implement privacy procedures.
3. Train employees so that they understand the privacy procedures.
4. Designate an individual responsible for ensuring that privacy practices are adopted and followed.
5. Secure patient records containing individually identifiable health information.

Permitted Uses and Disclosures

The HIPAA Privacy Rule generally requires that we make reasonable efforts to limit the use or disclosure of, and requests for, PHI to the minimum necessary to accomplish the intended purpose. We may use/disclose your PHI *without* consent in the following cases:

1. Treatment: The provision, coordination or management of health care and related services among health care providers or by health care providers with a third party, by one health care provider to another.
2. Payment: The various activities of health care providers to obtain payment or be reimbursed for their services and of a health plan to obtain premiums, to fulfill their covered responsibilities, and to obtain or provide reimbursement for the provision of health care. This includes determining eligibility or coverage under a plan, adjudication claims, billing and collection activities and justification of charges.
3. Health Care Operations: Administrative, financial, legal and quality improvement activities necessary to run our business including quality assessments, review of competence and qualifications of health care workers, accreditation, conduction or arranging for medical review, legal and auditing services and business management.

Your PHI may also be used/disclosed to inform you of health related products or services provided by Game Changer Physical Therapy, alternative treatments or therapies, or in any communications made during a face to face encounter with you.

KEEP THIS PAGE FOR YOUR RECORDS

Special Uses and Disclosures

Your PHI may be used/disclosed without your authorization in the following special circumstances:

- Law enforcement activities.
- Public health risks or activities.
- Reports to appropriate authorities concerning victims of abuse, neglect, or domestic violence.
- Health oversight activities and government benefit programs.
- Judicial and administrative proceedings (court order, warrant, and court subpoena for relevant information.)
- Emergency situations with serious threats to health or safety.
- Specialized government functions.
- Worker's compensation.
- Appointment reminders.
- Individuals involved (family/friends) in your care or payment for your care.
- Research, if conducted without using information that could reveal your identity. Military and Veterans, as required by military command authorities.

We may use/disclose your PHI for other purposes if you authorize the specific use/disclosure in writing. You may revoke this authorization at any time, but it must be in writing.

Your Rights Concerning your PHI

- You have the right to access and copy your "designated record set" (any piece of information that reflects a decision a provider makes regarding the patient). You may request that your record set, or portions of it, be copied. This request must be made in writing and may be subject to a reasonable copying charge. We have 30 days (50 in certain circumstances) to deliver the requested material to you.
- You have the right to receive an accounting of disclosures of your PHI. This excludes disclosures made to carry out treatment, payment for health care operations. An account would include disclosures made during the 6 years prior to the date of the request, and the date, recipient's name(s), description of PHI disclosed, and statement of purpose for the disclosure.
- You have the right to request amendments or corrections of your PHI. You must submit this request (see contact information at the end of this Notice) in writing and provide the reason for this request. In some circumstances we may have the right to deny your request. We will explain the reason for denial, and you may have the right to appeal the denial.
- You have the right to request additional restrictions or special limitations regarding how we use or disclose your PHI. We may deny this request, but if we agree to it then we will be legally obligated to carry out the agreement. This request must also be made in writing.
- You have the right to request alternative means of communication to increase confidentiality. You must specify how communication is to be carried out (written, phone, electronic, etc.) and any other limitations (specific address or phone number, etc.) in a written request. We will honor reasonable requests.
- You have the right to receive a paper copy of the Notice. We will issue a copy of the to you at the start of your course of treatment, and request that you sign a form stating you have received this form.

KEEP THIS PAGE FOR YOUR RECORDS

GAME CHANGER
PHYSICAL THERAPY

Changes to Privacy Practices
We have the right to make revisions to this Notice and to our privacy practices at any time. Revisions will apply to all PHI that we currently have, and any PHI that we obtain or generate in the future. Revisions will be posted with this Notice in our clinic and on our website.

Questions and Complaints
If you have any questions about this Notice, or would like an additional copy, please contact us at the information listed below. If you feel we have violated your privacy rights or disagree with a decision that has been made regarding your PHI, you may file a complaint with the Privacy Officer listed below, and/or with the Secretary of the U.S. Dept. of Health and Human Services. Please note that you will not be penalized for filing a complaint with us or DHHS.

Game Changer Physical Therapy, LLC
Attn: Privacy Officer, Natalie Jones
20325 N. 51st Ave. Suite 112, Glendale, AZ 85308
(623) 252-0646

You will not be penalized or otherwise retaliated against for filing a complaint. I ACKNOWLEDGE that I have received a copy of Game Changer Physical Therapy's Notice of privacy practices. I understand that this information describes how Game Changer Physical Therapy may disclose and use my Protected Health Information. (Signature on next page).

KEEP THIS PAGE FOR YOUR RECORDS

Game Changer Physical Therapy, LLC

Patient Name: _____

Date of Birth: _____

Acknowledgement of Receipt of Privacy Practices Notice

I, _____ (print name of patient or patient's personal representative), acknowledge that I have received a copy of Game Changer Physical Therapy's Notice of Privacy Practices. This Notice provides information about how we may use and disclose the medical information that we maintain about you. It also explains how you can access this information. By signing, you acknowledge that you have reviewed this Notice.

_____

Signature of Patient or Personal Representative Date

Consent to Leave Messages

To ensure confidentiality and comply with the Health Insurance Portability and Accountability Act (HIPAA), we ask that you let us know where and with whom we are permitted to leave information about your upcoming appointment, account information or any other information you may want us to convey via telephone or electronic messaging.

May we leave information on your mobile or phone phone voicemail? **YES / NO**
May we leave a message with someone who answers the phone at your residence? **YES / NO**
May we leave a message at your place of employment? **YES / NO**
May we call your spouse, partner, or emergency contact person to leave information? **YES / NO**

_____

Signature of Patient or Personal Representative Date

COMPLETE and RETURN THIS PAGE

Game Changer Physical Therapy, LLC
20325 N. 51st Ave. Suite 112, Glendale, AZ 85308
GameChangerPT.com - (623) 252-0646 - info@GameChangerPT.com

GAME CHANGER
PHYSICAL THERAPY

GAME CHANGER PHYSICAL THERAPY

CONDITIONS & CONSENT FOR PHYSICAL THERAPY

PLEASE FILL OUT and BRING WITH YOU to your first appointment.

As a patient you have the right to be informed about your health condition(s) and about recommended rehabilitation treatments. This document provides information that you may use for the purpose of deciding to give or to withhold your consent to be provided with care at Game Changer Physical Therapy, LLC.

I, _____, request and consent to examination and treatment for Physical Therapy and/or personal training. I further understand that I have the right to ask questions about:

- all aspects of examination and treatment, my condition, diagnosis or prognosis
- the nature or goals and potential benefits of any proposed care
- the inherent risks, complications, or side effects of treatment
- the likelihood of improvement or success following intervention
- reasonable, available alternatives to the suggested care and character of treatment

Potential risks I may experience include an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my therapist.

Potential benefits I may experience include an improvement in my symptoms and an increase in my ability to perform movement and daily activities. I may experience increased strength, awareness, flexibility and endurance with activity. I may experience decreased pain and discomfort. I will learn strategies for managing my condition and resources available to me will be shared.

If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider. It is anticipated that physical rehabilitation will allow improved function through decreased pain, increased strategies for managing pain, weakness, or immobility.

COOPERATION WITH TREATMENT: I understand that in order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances that prevent me from attending therapy. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

NO WARRANTY: I understand that the physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will share with me opinions and available statistics and studies regarding results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Game Changer Physical Therapy, LLC
20325 N. 51st Ave. Suite 112,Glendale, AZ 85308
GameChangerPT.com - (623) 252-0646 - info@GameChangerPT.com

FEE FOR SERVICE PRACTICE

FINANCIAL AND INSURANCE RESPONSIBILITIES:

- I have reviewed the clinic fees and understand that I am responsible for payment at the time of services.
- I understand it is my responsibility to call my insurance company ahead of time, obtain any pre- authorization that is necessary, and get an estimate of my benefits.
- I understand that I may request a receipt (Superbill) from my therapist, and that is my responsibility to submit to my insurance company if desired.
- I understand that I will not be able to submit for reimbursement by Medicare.

I hereby voluntarily consent to physical therapy treatment. I understand that I may choose to discontinue treatment at any time.

_____	_____	_____
Patient Signature	Printed Name	Date
_____	_____	_____
Guardian Signature	Printed Name	Date

How to Determine Your Insurance Benefits for Physical Therapy

1. Call the toll free # for customer service on your insurance card. Select the option that will allow you to speak with a customer service provider, not an automated system.

2. Ask the customer service provider to quote your physical therapy benefits in general. These are frequently termed rehabilitation benefits and can include occupational therapy, speech therapy, and sometimes massage therapy.

3. Make sure the customer service provider understands you are seeing a non-preferred or out-of-network provider.

What YOU need to know:

Do you have a deductible? Yes / No

If yes, how much is it? _____

How much has already been met? _____

What percentage of reimbursement do you have? (60%, 80%, 90%, are all common) _____

Does the rate of reimbursement change because you're seeing a non-preferred provider? Yes / No

Does your policy require a written prescription from your primary care physician? Yes / No

If yes, will a written prescription from any MD/physician, or a specialist your PCP (primary care physician) referred you to be accepted? Yes / No

Does your policy require pre-authorization or a referral on file for outpatient physical therapy services? Yes / No

- If yes, do they have one on file? Yes / No
- Is there a $ or visit limit per year? Yes / No If Yes, What is it? _____
- Do you require a special form to be filled out to submit a claim? Yes / No How do I obtain it?
- What is the mailing address you should submit claims/ reimbursement forms to?

  _____
- Is there an online website where you can submit the claim? Yes / No What is it?_____

What this information means:

• A deductible must be satisfied before the insurance company will pay for therapy treatment. Submit all bills to help reach the deductible amount.

• If you have an office visit co-pay the insurance company will subtract that amount from the percentage they will pay. This will affect the amount of reimbursement you will receive.

• The reimbursement percentage will be based on your insurance company's established "reasonable and customary/fair price" for the service codes rendered. This price will not necessarily match the charges billed; some may be less, some may be more.

• If your policy requires a prescription or referral from your PCP you must obtain one to send in with the claim. This is usually not difficult to obtain if your PCP sent you to a specialist for help with your condition. If the referral from a MD or specialist is all you need, make sure to have a copy to include with your claim. Each time you receive an updated referral you'll need to include it with the claim.

• If your policy requires pre-authorization or a referral on file and the insurance company doesn't have one listed yet, you'll need to call the referral coordinator at your PCP's office. Ask them to file a referral for your physical therapy treatment that is dated to cover your first physical therapy visit. Be aware that referrals and pre-authorizations have an expiration date and some set a visit limit. If you are approaching the expiration date or visit limit you'll need the referral coordinator to submit a request for more treatment.

This worksheet was created to assist you in obtaining reimbursement for Physical Therapy services and is not a guarantee of reimbursement to you.

Please contact us if you have any further questions or would like help understanding your benefits.

KEEP THIS WORKSHEET FOR YOUR RECORDS