SURGE
MOBILE PHYSICAL THERAPY

PATIENT INTAKE COMMERCIAL ENGLISH

SURGE
MOBILE PHYSICAL THERAPY

Dear Patient/ authorized representative,

Don’t just sign on these forms...

Actually READ through what you are signing

to prevent confusion later.

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Welcome to Surge Mobile Physical Therapy! We strive to provide our patients with excellent service & quality care. Our commitment to your well-being and health care is something that we take very seriously.

The most important question: Do you want to be here? Are you ready and willing to put in the work on your part to reach your personal physical goals?

Remember that we are here to help YOU reach your physical goals, however, we cannot force anyone to come to therapy to get results....

This means that if you are NOT fully convinced that physical therapy can help you, more than likely it will not, and you should not waste your valuable time here. Research shows that having a positive and willing mindset is key to succeeding in your physical therapy journey!

If you are serious about your physical care and are ready to get started, continue.

COMMERCIAL INSURANCE
Patient Intake Form

***All* Patients or Patients' Legal Representative, please complete all Sections**

(1) Patient: (Full Legal Name or as on Insurance Card)

Name: Last First Initial Sr. Jr.

Address: Street Apt# City State Zip Code

Phone: (_____) _____-_____ (_____) _____-_____ (_____) _____-_____ (_____) _____-_____
Home Mobile Work Emergency

EMAIL:_____

(2) Patient:

Assigned Sex _____ **Birthdate:** _____/_____/_____

S.S # XXX / XX /_____ **Legal Photo ID #** _____
(Driver's License, Passport, Other State/Federal Photo ID)

(3) Condition to be treated: _____

Date condition began?			Date:____/____/____
Is it related to an auto accident?	No	Yes	Date of accident ____/____/____
Is it a non-work related accident?	No	Yes	Date of accident ____/____/____
Did this condition result in surgery?	No	Yes	If Yes, date of surgery ____/____/____
Have You Had therapy for this Condition?	No	Yes	If Yes, PT OT SLP Where?_____
Have you had chiropractic services for this condition?	No	Yes	If Yes, where?_____ If Yes, when? _____

(4) Patient's Doctor: Please list the Doctor who referred you to therapy or your Primary Care doctor

Office Phone: (____) _____-_____

Dr's Name: Last First Initial MD, DO, DDS, Other

Address: Street City,State Zip Code

All Patients or Patients' Legal Representative Please Sign Section 11 on Page 3

COMMERCIAL INSURANCE
Patient Intake Form

(5) If Filing Insurance : Check A or B

A. ____ **Patient is the insured** (Do not need to complete the rest of #5 or any of #6)

B. ____ **Insured is** ___**Spouse** ____**Parent** (Complete all of #5 and all of #6)

Name: Last First Initial Sr./Jr.

Address: Street Apt.# City State Zip Code

Phone: (___) ____-_____ (___) ____-_____ (___) ____-_____ (___) ____-____
Home Mobile Work Emergency

(6) Insured Person: Complete if not the patient

Date of Birth: ____/____/____ **S.S. #** XXX / XX /_____

Legal ID # _____ **Employment Status:** ___ **Employed** ___ **Unemployed** ___ **Retired**

(7) Employer Information (Please complete if the insured person's employer is the source of benefits)

Employer Name: _____ **Employer Phone # (** **)** _____**-** _____

Address: _____ _____
Street City State Zip Code

Name of Employer Contact: _____ **Contact's Phone # (** **)** _____**-** _____

(8) Payer Information:

Primary Insurance Company:

Ins. Co. Name: _____ **Insured's Name:** _____ **Ins. Ph #**_____

Patient ID #: _____**Group. #** _____ **Policy/Plan #:** _____

Secondary Insurance Company: (If YES, please complete) **Insured is:** _____**Patient** _____**Spouse** _____**Parent**

Ins. Co. Name: _____ **Insured's Name:** _____ **Ins. Ph#**_____

Patient ID #: _____**Group. #** _____ **Policy/Plan #:** _____

Claims Mailing Address:_____
Street City State Zip Code

Employer Name: _____ **Employer Phone # (** **)** _____**-** _____

Address: _____ _____
Street City State Zip Code

All Patients or Patients' Legal Representative Please Sign Section 11 on Page 3

COMMERCIAL INSURANCE
Patient Intake Form

(9) Payment Authorization: ***(Initials required for all 3 statements)***

_____ **Assignment of Insurance Benefits**

Initials

I authorize that the payment of my insurance benefits be made directly to Surge Mobile Physical Therapy for all services delivered; if I am paid directly I will promptly pay Surge Mobile Physical Therapy all monies paid to me

_____ **Guarantee of Payment**

Initials **I understand that all payments designated as 'the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility' by my insurer by the statement due date**

_____ **Certification of Information**

Initials **I certify that the information I have provided Surge Mobile Physical Therapy for payment including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful**

(10) Authorization to treat minor child or dependent adult

_____ **I consent to permit the evaluation and treatment of the patient noted on page 1 based on the Plan of Care established by the therapist and approved by me. This includes my consent to the audiovisual recording of all evaluation and treatment sessions. As the legal representative I am permitted, under HIPAA, to access and or obtain copies of all related records maintained.**

Initials

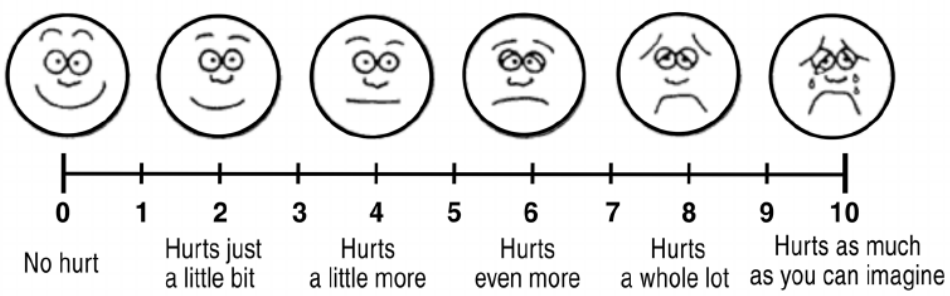
(11) Signature/ Date: I agree to all of the above. I hereby authorize the professional staff at Surge Mobile Physical Therapy to examine and treat me with outpatient physical therapy services for the injury or condition that I have been referred here for/referred myself to.

X _____ _____

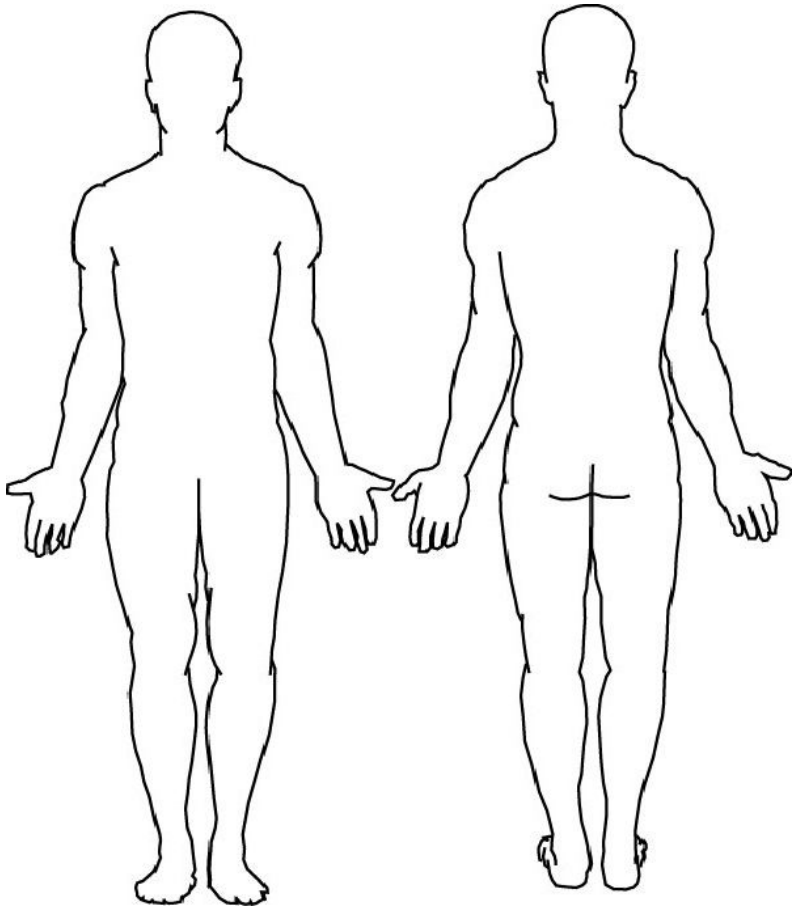
Patient or Legal Representative's Signature **Today's Date**

All Patients or Patients' Legal Representative Please Sign Section 11 on Page 3

Circle Your Pain Level:



Circle location to be treated below:



SURGE
MOBILE PHYSICAL THERAPY

Initials are required by each Policy. By initialing, you understand and agree to adhere to all policies.

Medical Records Request Policy

_____Initials. **If you need any medical forms signed by our staff or need to get copies of your medical information, please allow up to 30 days of your request via email. If you request printed or email copies, there will be an associated fee for compiling and/or printing the documents: $25 for 1-20 pages, $0.50 per page thereafter.**

Be Kind Policy

_____Initials. **Please be aware that if you are rude, aggressive, disrespectful, or inappropriate either verbally/physically to our staff/other patients, we reserve the right to refuse services and you will be asked to leave our establishment as this behavior will not be tolerated.**

Commitment Policy

_____Initials. **Your commitment to your physical therapy program is critical to your success. We will recommend a treatment plan of care and set goals for you. In order to reach those goals, you must do your part in attending every appointment AND doing your Homework Exercise Program as prescribed to see progress.It takes at least 8-10 weeks to see changes in musculoskeletal tissue!**

Valid Card of File Policy

_____Initials. **We require every patient to keep a VALID debit/credit card on their account due to the $50 policy violations & in case insurance does not cover services, & to issue out refunds to go directly back to your card instead of waiting for a mailed check later on after your case is closed.**

Appointment Policy

_____Initials. **We will text you appointment reminders. When you receive these, confirm your appointment by replying with the letter "C" ONLY. If you type anything else, we will NOT receive your response, and DO NOT KNOW YOU ARE COMING. We will schedule & provide you with your appointment times when you check out, ask for a print out if needed. If you misplace or forget your appointment times, please ask our front office staff, call, or text us to review these.**

Arrive on Time Policy

_____Initials. **Our goal is to begin your treatment sessions on schedule. Arrive at least 5 minutes prior to your appointment time, dressed comfortably, & be ready to begin.**

Communication of changes

_____Initials. **We may need to reschedule some of your appointments due to therapist availability, especially in emergency cases.**

_____Initials. **For your health safety, we require a letter of medical clearance after any patient hospitalizations to make sure you are safe to return to physical activity in therapy.**

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$50 NO SHOW / LATE CANCELLATION POLICY

We take your Physical Therapy VERY SERIOUSLY, because we care about your physical health. It takes time to see progress with therapy, and in order to get you better, we expect you to follow our recommended plan of care and to keep all your appointments. We also understand there may be a time when you need to cancel. We require 24-hour notice by phone call, voicemail, text, or email (missed calls do not count) if you need to cancel or reschedule. If you do not give 24 hour notice or do no show for your scheduled appointment, a $50.00 fee will be billed to your account, and it must be paid in order to continue your therapy sessions. If you're running late, call us immediately to check if we can accommodate for your late arrival. If you do not let us know you are going to be late and you show up >15 min late to your appointment, your session may need to be rescheduled, and we reserve the right to charge the fee for the lost session. When you cancel your appt on the SAME day of your appointment, to AVOID the $50 cancellation fee, you need to reschedule it during the same week. IF YOU DO NOT RESCHEDULE THIS MISSED APPOINTMENT DURING THE SAME WEEK, YOU HAVE MISSED YOUR APPOINTMENT & THEREFORE WIL BE CHARGED THE $50 CANCEL FEE. If you have more than 3 same-day cancellations OR no-shows, your case will be discharged,& we will notify your Referring Doctor.

Why do we charge the is fee? We do this to be respectful of everyone's time, you as the patient, us as the therapist, and to be fair to other patients that are making the time and effort to make it to every single appointment. When you do not show up to your scheduled appointment or cancel last minute, it wastes a slot that could have helped someone else get better. AGAIN, We take your physical health very seriously!

Patient/Guardian Printed Name **Date**

X

Patient/Guardian Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Surge Mobile Physical Therapy to release any of my protected healthcare information.

My signature below indicates that I have been given this Notice of Privacy Practices for Surge Mobile Physical Therapy.

_____

Patient's or Authorized Representative's Printed Name

X _____

Patient's or Authorized Representative's Signature

_____

Date

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Patient Payer Insurance Verification Form

Patient Name:_____

Date Verified:_____ Verified By: _____

As a courtesy to you, we contacted your insurance company to check your available Outpatient Physical Therapy Benefits. Below is a summary of the information we were given. If you have any questions regarding your financial responsibilities, please ask. **We strongly recommend that you also contact your insurance carrier to confirm your benefits as we are sometimes given information that may be incorrect. Surge Mobile Physical Therapy is NOT responsible for any inaccurate information we receive and will bill you for any balances that your insurance company indicates as your responsibility/not covered.** The benefit coverage information that we receive from your insurance is always an estimate, NOT a guarantee of full coverage for services rendered. Any estimated amounts not covered by your insurance that are your responsibility are due at the time of your visit and must be paid in order to render services. After we send your claims to your insurance, all your visit claims are subject to final approval by your insurance plan after we render services; therefore, the amount due is subject to change after we see you. Inform the front office staff of ANY changes to you insurance coverage or if your insurance has terminated at the time of services. Any due balances remaining for your care will be billed to you via mail and email, and you may pay via mailed check, by calling the clinics- Olmito (956) 413-7799, Port Isabel (956) 443-3844, or online through our website at www.surgemobilephysicaltherapy.com. Any unpaid past due balances with more than 120 days of non-payment will be sent to collections.

Patient Diagnosis Info:

Areas to be treated per referral: _____

Payer Info:

Primary Insurance:_____

Benefits Effective: _____Plan Year:_____ Visits Allowed:_____Visit used:_____

Adjustor Name:_____Phone:_____Fax:_____

Network: IN | OUT | Out but Auth

Your policy requires: Referral from Physician | Pre-Authorization

According to your insurance, your Responsibility for payment is as follows:

Co-Pay:_____ Co-Insurance%:_____

Deductible Met: YES | NO. Remaining Amount To Be Met:_____
1st Authorization #: _____Time Restriction:_____ Visit Restriction:_____

Comments:_____

Secondary Insurance:_____

Benefits Effective: _____Plan Year:_____ Visits Allowed:_____Visit used:_____

Adjustor Name:_____Phone:_____Fax:_____

Network: IN | OUT | Out but Auth

Your policy requires: Referral from Physician | Pre-Authorization

According to your insurance, your Responsibility for payment is as follows:

Co-Pay:_____ Co-Insurance%:_____

Deductible Met: YES | NO Remaining Amount To Be Met:_____

1st Authorization #: _____Time Restriction:_____ Visit Restriction:_____

Liability Claims/Facility LOP Obtained on:_____

Comments: _____

PAYMENT RESPONSIBILITY ACKNOWLEDGEMENT
FOR INSURED PATIENTS

Co-Pay or Co-Insurance Due Each Visit: _____

Current Patient Balance**:** _____

If this is only a portion if what your payment responsibility is per visit, you will be billed monthly for the remaining portion. All copayments and coinsurances and deductibles are expected at check in.

I understand & agree to my insurance benefit & payment information.

_____ _____

Patient/Guardian Printed Name **Date**

X _____

Patient/Guardian Signature

Texas Board of Physical Therapy Examiners

1801 Congress Ave Ste 10.900 ***512/305-6900***
Austin, Texas 78701 ***ptot.texas.gov***

Physical Therapy Treatment without Referral Disclosure

Please read carefully and acknowledge below:

I understand that physical therapy treatment without a referral will be based on the physical therapist's examination and evaluation of my current condition which may result in identification of movement and mobility dysfunction.

I understand that the physical therapist will not diagnose an illness or disease, and that physical therapy is not a substitute for a medical diagnosis.

I understand that if a medical diagnosis has already been established by a qualified healthcare practitioner, the physical therapist will take it into consideration during the evaluation process.

I understand that the physical therapy plan of care developed by the physical therapist may not be based on radiological imaging.

I understand that if images have previously been obtained, the physical therapist may use the information as part of the evaluation process.

I understand that if the physical therapist identifies a need for radiological imaging, the physical therapist may recommend that radiological imaging be obtained.

I understand that my health insurance may not cover physical therapy services if provided without a referral from a qualified healthcare practitioner.

I acknowledge that I have received the above disclosure.

Patient Name (print): _____

_____ _____
Signature of Patient or Legal Representative Date

_____
If Signed by Legal Representative, Print Name and Relationship to Patient

Approved by the Texas Board of Physical Therapy Examiners – 10/11/2019

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Payment types accepted:

- **DEBIT/ CREDIT CARD**
- **CHECKS:**
  - **RETURNED CHECK FEE: $5**
- **EXACT CASH**
- **CARE CREDIT**
- **CASH APP : $SurgePT**

Tipo de Pago Aceptado:

- **TARJETA DEBITO/CREDITO**
- **CHEQUES**
  - **CARGO POR CHEQUE DEVUELTO: $5**
- **EFFECTIVO EXACTO**
- **CARE CREDIT**
- **CASH APP : $SurgePT**

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Questions about your bill?

Any questions about your bill you need to contact the billing department directly, as they handle any billing or refund issues. If you keep calling the clinic for any billing issues it will take longer as we still have to contact the billing department.

Phone number: 406-315-7395

¿Tiene preguntas sobre su factura?

Si tiene alguna pregunta sobre su factura, debe comunicarse directamente con el departamento de facturación, ya que ellos se encargan de cualquier problema de facturación o reembolso. Si continúa llamando a la clínica por cualquier problema de facturación, tardará más tiempo, ya que aún tenemos que comunicarnos con el departamento de facturación.

Número de teléfono: 406-315-7395

THE FOLLOWING FORMS ARE OPTIONAL ...

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Dry Needling Consent for Physical Therapy Treatment

What is it? Dry Needling is a form of physical therapy in which fine needles are inserted into myofascial trigger points (i.e., painful knots in muscles), tendons, ligaments, or near nerves to help stimulate a healing response process in painful musculoskeletal conditions. Dry Needling is not acupuncture or Oriental Medicine; in other words, it does not have the purpose of changing the flow of energy ("Qi") along traditional Chinese meridians for the treatment of diseases. In fact, dry needling is a modern, science and evidence-based physical therapy intervention for the treatment of musculoskeletal pain and dysfunction.

We offer Dry Needling as a separate WELLNESS SERVICE. If interested in Dry Needling services, speak to your therapist. Our cost is $50 (CPT code 20560) for Dry Needling 1-2 Muscles/ using 1-2 Needles, and $100 (CPT code 20561) for Dry Needling 3 or more muscles/ using 3 or more needles.

Is it safe? After treatment some patients may experience temporary pain during and after the treatment, temporary soreness feeling (sometimes a few days), drowsiness, tiredness, or dizziness in about <3% of patients (if so, we advise you not to drive), minor bleeding or bruising (is considered normal), worsening of existing symptoms in about <3% of patients (which is not necessarily a bad sign), fainting (especially when needling the head and neck areas). Dry needling is very safe. However, serious side effects can occur in less than 1 per 10,000 treatments. The most common serious side effects is a pneumothorax/lung collapse (from air inside the chest wall). The symptoms of dry needling-induced pneumothorax commonly do not occur until after the treatment session, sometimes taking several hours to develop. The signs and symptoms of a pneumothorax may include shortness of breath on exertion, increased breathing rate, chest pain, dry cough, bluish discoloration of the skin, or excessive sweating. If such symptoms occur, you should immediately contact your physical therapist or medical physician. Nerves or blood vessels may be damaged from dry needling which can result in pain, numbness/tingling; however, this is a very rare event and is usually temporary. Damage to internal organs has been reported in the medical literature following needling; however, these are extremely rare events (1 in 200,000). Only single-use, disposable needles are used in this clinic. **Let your therapist know if you have:** Seizures, pacemaker/implants, taking anticoagulants, antibiotics for an infection, damaged heart valve, metal prosthesis, risk of infection, pregnant, metal allergies, diabetic impaired wound healing, hepatitis B, HIV, or other infectious disease.

I have read & understand the information above & will speak to my therapist if I am interested.

_____

Patient/Guardian Printed Name **Date**

X _____

Patient/Guardian Signature

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Photography/Testimonial Authorization Consent Form

(OPTIONAL)

Surge Mobile Physical Therapy uses photography/video/audio recordings for the purpose of:

* Analyzing your movements/posture during evaluations and throughout your episodes of care to track your progress.

* Analyzing your movements/posture during evaluations and throughout your episodes of care to track your progress.

* Posting successful testimonials or educational content on our website or other social media platforms.

* As a result, your or child's images/videos/voice/written testimonials may appear on our website or other social media platforms if you allow it.

Purpose of Authorization: By signing this authorization form, I am providing Surge Mobile Physical Therapy, hereafter identified as the Company, to distribute and share my/my child's client testimonial that is provided. Sharing my/my child's client testimonial may include posting the information on the company website, posting the testimonial information on the Company's social media pages, and including my/my child's testimonial on printed advertisements and promotions. I agree that I am voluntarily sharing my/my child's testimonial about services from the Company, and I am receiving no financial remuneration from the Company for providing such testimonial and allowing them to use my/my child's protected health information for marketing purposes.

Right to Revoke: I understand that I have the right to revoke this authorization at any time by providing a written request to the Company. I understand that if I choose to revoke this authorization, it will become effective on the day of the revocation of the authorization. Any prior uses and disclosures of my testimonial with my protected health information will not be subject to the revocation of the authorization. I understand that the Company will make it best effort to remove my testimonial and protected health information from the Company's website and other social media pages.

By signing below, I agree and acknowledge that I have read and understood all of the elements of this authorization for use of my/my child's client testimonial. This authorization is continuous, meaning Surge Mobile PT will not remove my/my child's testimonial from the website or other social media pages unless I specifically request a revocation of this authorization through a written request to the company. I release Surge Mobile Physical Therapy, from any and all liability that may arise in connection with such use. I certify that I am 18 years or older OR that my parent/guardian has signed below.

_____ _____

Patient/Parent/Guardian Printed Name **Date**

X_____

Patient/Parent/Guardian Signature

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PELVIC FLOOR EVAL & TREATMENT CONSENT FORM

* I acknowledge and understand that I have been referred for evaluation and treatment of pelvic floor dysfunction, Pelvic floor dysfunctions include, but are not limited to, urinary or fecal incontinence; difficulty with bowel, bladder, or sexual functions; painful scars after childbirth or surgery; persistent sacroiliac or low back pain; or pelvic pain conditions.

* I understand that to evaluate my condition it may be necessary, initially and periodically, to have my therapist perform an internal pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum, This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility, and function of the pelvic floor region. Such evaluation may include vaginal or rectal sensors for muscle biofeedback.

* Treatment may include, but not be limited to, the following: observation, palpation, use of vaginal weights, vaginal or rectal sensors for biofeedback and/or electrical stimulation, ultrasound, heat, cold, stretching and strengthening exercises, soft tissue and/or joint mobilization, and educational instruction.

* I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

By Signing for this section, I agree and understand all the above and below:

The purpose, risks, and benefits of this evaluation have been explained to me. I understand that I can terminate the procedure at any time. I understand that I am responsible for immediately telling the examiner if I am having any discomfort or unusual symptoms during the evaluation. I have the option of having a second person present in the room during the procedure If I choose to. I understand that I am responsible for communicating this with my examiner, and that I am responsible for bringing this second person to my appointment(s), as the clinic does not provide one at this time.

By signing Below, I have read, understand, and agree with the Pelvic Floor Consent Form.

_____ _____

Patient/Parent/Guardian Printed Name **Date**

X_____

Patient/Parent/Guardian Signature

AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization is not required for the Use or Disclosure of Information Related to Treatment, Payment, Healthcare Operations or if Required by Law or Rules

You May Refuse to Sign this Authorization

(1) **Patient's Printed Name**:

_____
Last First Initial or Other

Date of Birth: ____/_____/___ Insurance # exactly as on card (including letters)_____

(2) Surge Mobile Physical Therapy will only disclose the protected health information you want disclosed.

Check only one box to tell Surge Mobile Physical Therapy the specific information you want disclosed/released:

☐ Do NOT release any information other than for treatment or payment (skip sections 3-5.continue to section 6)

☐ Limited information (complete ALL Sections)

☐ ALL records regarding my care at Surge Mobile Physical Therapy to any requesting party (skip 3 and 4)

(3) Complete only if you selected "limited information". Please initial all that apply:

_____ Evaluation/Examination _____ Attendance _____ Correspondence re: your Physical Therapy Services
_____ Past Medical History _____ Treatments _____Other _____

(4) Complete only if you selected "limited information". I only authorize the release of information to the individuals/entities identified below by name:

Spouse: _____ Attorney: _____
Parent: _____ Employer: _____
Friend: _____ School: _____
Other: _____ Other: _____

(5) Check only one box indicating how long Surge Mobile Physical Therapy can use this authorization:

☐ Disclose my information indefinitely (as long as Surge Mobile Physical Therapy has custody of my files)

☐ Disclose my PHI for the following period beginning ___/___/_____ and ending ___/___/_____

(6) Please initial all items below indicating that you have read and understand the rights or information below:

_____ I understand that this authorization does not expire unless I have indicated an expiration date above
_____ I understand that I can refuse to give authorization without fear of retaliation or treatment limitations
_____ I understand that if I give authorization I may revoke it at any time by notifying this Surge Mobile Physical Therapy in writing
_____ I understand that the information used/disclosed as a result of my authorization may be subject to re-disclosure by the recipient and may not be protected by Federal privacy regulations once in the recipient's possession
_____ I understand that if Surge Mobile Physical Therapy requests my authorization it is required to tell me the purpose and to whom my PHI (protected health information) is being released to
_____ I understand that I will receive a copy of this authorization after I sign it and before I sign, if I request it
_____ Surge Mobile Physical therapy will not be compensated for using or disclosing my PHI unless related to treatment or payment procedures unless specific permission is obtained by the patient after full disclose of purpose & intent

X_____ **or** _____

Signature of Patient **Date** **Signature of Parent or Authorized Representative Date (Indicate the Relationship)**