Missed Appointment Policy

(With the exception of serious emergencies) It is expected that you keep all of your appointments. If you need to reschedule an appointment we require a 12 hour notice. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionists. The make-up appointment needs to be made in the same week, preferably the very next day. Telehealth visits may be covered by your insurance, please inquire with our Front Office staff, as this can be a make-up appointment.

Any canceled visit within a 12 hour period prior to your scheduled appointment; we reserve the right to charge you a $75.00 fee. If you are charged a cancellation fee, it will need to be paid prior to your next treatment session.

Any missed, no show appointments, or tardiness where you cannot be seen; we reserve the right to charge you a $100.00 fee. This fee will need to be paid prior to your next treatment session.

In instances of repeated non-compliance with your scheduled visits, we also reserve the right to discontinue care and will inform your physician/claims adjuster that services provided to you have been discontinued due to non-compliance with the prescribed plan of care and will be given your attendance history.

Financial Policy

TO OUR VALUED PATIENTS:

Payment for services are due at each visit for charges incurred through your last visit. We accept cash, checks, MasterCard, Visa, Discover, FSA, and HSA.

Please read carefully:
For liability cases, where another party is responsible, you need to provide us with all the billing information. If you have an attorney please provide this information on the designated form for the type of incident. It is Houghton's policy that a letter of protection, also known as a Lien must be received from your attorney within the first 2 weeks of treatment. Without this letter, you become responsible for the account in full.

Medicare patients are responsible for the yearly deductible and if Medicare is the only insurance, you are responsible for the 20% co-insurance.

Notice of Privacy Practices and HIPAA

Consent to Treat/HIPAA

I agree to release medical information to discuss my condition with corresponding medical offices, insurance companies, attorney offices, and worker's compensation offices related to my condition. I hereby authorize Houghton Physical Therapy, LLC. to provide information to the insurance carriers concerning my treatment and hereby assign all payments for services rendered. I understand that I am responsible for all charges, even those not covered under my insurance.

I hereby authorize Houghton Physical Therapy to perform outpatient diagnostics/procedures and to administer necessary/appropriate outpatient therapy. I understand that by signing I am giving permission for treatment.

I have read and understand the above missed appointment policy, financial policy, and HIPAA Privacy Act.

Patient Signature:____ **Date:**_______________

Parent Signature:____
(If patient is younger than 18 y/o)

Houghton Physical Therapy Patient Registration

Patient Information/Registration

Name:____ **DOB:**______________
First **Last** **M.I.**

Assigned Gender:_______________ **Marital Status:** ______________ **SSN:**_______________
Req. for WC

Address:____
Street **Unit #** **City/Town** **State** **Zip**

Phone:_____________________________ **Sec. Phone:**_____________________________

Cell____ **Home**____ **Work**____ **Cell**____ **Home**____ **Work**____

Email:____

How would you like to receive appointment reminders? **Text**_______ **Email**_______ **Both**______

Emergency Contact:____
First **Last**

Relation:___________________**Phone:**____________________**Type:Cell**___**Home**___**Work**___

Body Part to be Treated:___________________________________ **Right**___ **Left**___ **Bilat.**____

Referring Doctor:______________________________________ **Phone:**_________________

☐ **Is this Doctor your P.C.P.?**

Primary Care Doctor:___________________________________ **Phone:**_________________

Is this injury related to: M.V.A._____ **W.C.**_____ **Liability**_____ **Surgery**_____ **DOI:**______________
(DOI or Surgery Date)

How did you hear about us? Doctor___**Returning Patient**___**Friend**___**Walk-In**___**Google**___

Community Event____ **Social Media**____ **Newspaper**____**Golden Ticket**____

Who may we thank for your referral?:____

Insurance

Primary Health Insurance:____

Member ID#________________________________ **Group #**__________________

Policy Holder:____ **(If 'Self' write Self)**
Name (First, Last, MI)
Relation:________________________________ **DOB:**_____________________

Address:____

Secondary Insurance (if any):____

Member ID#________________________________ **Group #**__________________

Policy Holder:____ **(If 'Self' write Self)**
Name (First, Last, MI)
Relation:________________________________ **DOB:**_____________________

Address:____

Tertiary Insurance (if any):____

Member ID#________________________________ **Group #**__________________

Policy Holder:____ **(If 'Self' write Self)**
Name (First, Last, MI)
Relation:________________________________ **DOB:**_____________________

Address:____

Have you recently been discharged from the hospital, a skilled nursing facility, or Home Health Agency in the past 30 days related to this condition? Yes_____ No_____ (if yes, please specify the facility and discharge date):____

<u>Please Read the Following Statement***</u>***

If this case is related to a Motor Vehicle Accident, Workers Compensation Accident, or Liability Claim, please notify our front office staff and have the accident information ready.

Medical History

Name:____ **DOB:**_________________

Height:____ **Weight:**________________________

What brings you in today? (Please explain the cause, if known, and how this injury occurred):

____

____

____

Have you had any tests done for this injury? If yes, please specify:_________________________

____

Average Level of Pain (1-10):_______ **Describe the character of your pain:**__________________
(Sharp/Dull/Achy/Other)

Do you have numbness, tingling, or weakness?__________ **Does the pain move/radiate?**_______

Any changes in bowel, bladder, or sexual function as a result of your symptoms? Yes____ No____

Have you seen any other doctor or specialist for this condition? Yes____ No____ (If yes, please specify) ____

Have any treatments been done for this injury/episode? Yes___ No___ (if yes, please specify)

____

Is this injury the result of a fall in the past year? Yes___ No___

Have you had 2 or more falls in the last year? Yes___ No___

Is this injury related to a surgical procedure? Yes___ No___ (if yes, please specify the surgery and date of the operation)____

Please list any other surgeries performed in the past: ___________________________________

____

____

Are you currently taking any medications (prescription and non-prescription)? Yes___ No___

Please list your medications or attach a copy of your medication list (if applicable)

Name	Dosage	Frequency	Route (Oral/topical/etc)	Reason for Taking

Please Check Yes or No to the following Medical Conditions

	Yes	No		Yes	No
Allergies			Hearing Impairment		
Anemia			Hepatitis		
Anxiety			High Cholesterol		
Arthritis			High/Low Blood Pressure		
Asthma			HIV/AIDS		
Autoimmune Disorder			Incontinence		
Cancer			Kidney Problems		
Cardiac Conditions			Metal Implants		
Cardiac Pacemaker			MRSA		
Chemical Dependency			Multiple Sclerosis		
Circulation Problems			Muscular Disease		
Covid-19			Osteoporosis		
Currently Pregnant			Parkinsons		
Depression			Rheumatoid Arthritis		
Diabetes			Seizures		
Dizzy Spells/Vertigo			Smoking		
Emphysema/Bronchitis			Speech Problems		
Fibromyalgia			Stroke		

Fractures			Thyroid Disease		
Gallbladder Issues			Tuberculosis		
Headaches			Vision Problems		

If you checked Yes to any medical conditions listed above, please explain and give approximate dates/describe any other conditions: ____

____

____

____

I certify that I have filled out the patient registration, insurance section, medical history, and all corresponding forms to the best of my ability and knowledge.

Patient Signature:____**Date:**__________________