Physical Therapy Services at Cypress

Karl R. Glick P.T. Steve W. Vequist P.T. Jill D. Austin P.T. Julie Waltemath P.T.

9300 E. 29th St. N., Ste. 206 Wichita, KS 67226

You are scheduled for physical therapy with Karl R Glick L.P.T., Steve W Vequist L.P.T., Jill D Austin L.P.T., or Julie A Waltemath D.P.T. on ___________________ at __________________ a.m. p.m.

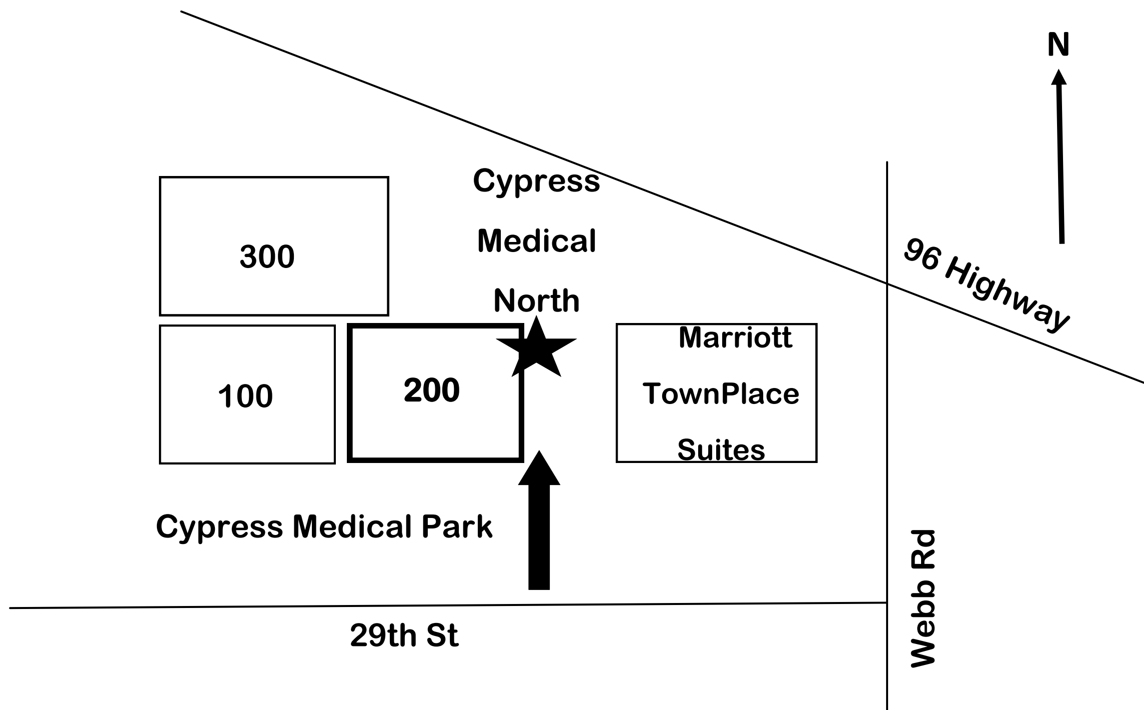
Please arrive for your appointment **15 minutes early** and have the following:

- If you have a managed care HMO, you must have a referral from your primary care doctor.
- Current Insurance Card
- If under 18 years old, you must have a parent or legal guardian
- ***Co-Pay due at time of visit***. We accept cash, checks, or VISA/Mastercard
- Pictures from surgery, if post-op
- Appropriate attire:
  - Shoulder – Tank Top
  - Knee – Shorts
  - Loose fitting clothes for low back evaluations

Failure to keep or cancel appointment within 24 hours of scheduled appointment time will result in a $25 service fee not payable by insurance.

We are located at the Northeast corner of the Cypress Medical Office Park at the "Cypress Medical North" entrance, 9300 E 29th, Suite 206.

If you have any questions about insurance or your appointment, please feel free to contact us at 316-858-1177. We look forward to seeing you!



Patient Information

Name (Last)________________________________ (First)___________________________ (M.I)______

Date of Birth ________/_______/__________ Age ______ S.S.#___________-_________-_________________

Address ___________________________________ City__________________ State_______ Zip__________

Home Phone (____) _____________ Cell Phone (____) _____________ Work Phone (____) _____________

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

☐ Employed ☐ Unemployed ☐ Student Full Time/Part Time ☐ Retired

Employer ___________________________________ Address ____________________________________

City______________________________ State ______ Zip ______________ Phone (____) _____________

Emergency Contact _________________________ Relationship ___________ Phone (____) _____________

Mail Bill/Statement to ☐Patient or ☐Other _______________________________ Relationship____________

Address ___________________________________ City__________________ State_______ Zip__________

Referring Physician(s)____

Primary Insurance Policy Holder / Responsible Party (<u>If not patient</u>)

Name (Last)________________________________ (First)___________________________ (M.I)______

S.S.#________-______-_________ Date of Birth ______/______/________ Relationship to Patient__________

Address ___________________________________ City__________________ State_______ Zip__________

Home Phone (____) _____________ Cell Phone (____) _____________ Work Phone (____) _____________

Employer ___________________________________ Address ____________________________________

City______________________________ State ______ Zip ______________ Phone (____) _____________

Secondary Insurance Policy Holder / Responsible Party (<u>If not patient</u>)

Name (Last)________________________________ (First)___________________________ (M.I)______

S.S.#________-______-_________ Date of Birth ______/______/________ Relationship to Patient__________

Address ___________________________________ City__________________ State_______ Zip__________

Home Phone (____) _____________ Cell Phone (____) _____________ Work Phone (____) _____________

Employer ___________________________________ Address ____________________________________

City______________________________ State ______ Zip ______________ Phone (____) _____________

Physical Therapy Services at Cypress Consent Form

Consent: I consent to physical therapy services at Physical Therapy Services at Cypress. I know if I have any questions about my care, I should be sure to ask the physical therapist about them. I know it is up to me to inform the physical therapist about any health problems or allergies I have. I must also tell the physical therapist about drugs or medications I am taking. I understand that a physical therapy diagnosis is not a medical diagnosis by a physician.

Insurance: I authorize the staff at Physical Therapy Services at Cypress to review my insurance coverage with my insurance company. **I understand that my insurance benefits are only a quote of benefits and not a guarantee of payment. I understand that what I am quoted by PT/or my insurance company may differ from what I may owe at the conclusion of physical therapy. I understand it is my responsibility as the patient to know my insurance coverage. I authorize payment of my insurance benefits to be made directly to Physical Therapy Services at Cypress. I agree to pay in full any and all charges not covered by insurance or other benefits. I understand that it is unlawful for Physical Therapy Services at Cypress to waive co-pays, co-insurances and deductibles that are my responsibility.**

Financial: I understand that a $25 fee will be added to my bill for any returned check. If I do not pay my outstanding balance within 90 days, my balance may be sent to a collection agency and a 1.5% percent fee will be added to the unpaid balance monthly. These fees will be my responsibility.

Release of Information: Physical Therapy Services at Cypress releases patient health care information for purposes of treatment, payment, or to other health care organizations, as explained in our HIPAA Notice. I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits. I understand that I may restrict my personal health information from anyone by submitting a written request.

No Guarantees: I understand that the practice of physical therapy is not an exact science and that no guarantees or promises have been made to me as a result of treatments or examinations by the physical therapist. I understand that no contract, warranty, guarantee, or promise concerning the results of the physical therapy services I made. This consent to treatment form is not a contract, nor is it an offer to contract, nor is it an acceptance of an offer to contract.

Notice of Privacy Practice: I have read the Physical Therapy Services at Cypress Privacy Notice located on the back of this form and I understand that a copy of the notice will be provided to me upon my request.

Cancel/No Show/Late Policy: If you must cancel your scheduled appointment, a 24-hour notice is required. **Cancels with less than 24-hour notice and no shows may result in a $25 fee. You are individually responsible for this fee, not your insurance company.** If you arrive more than 10 minutes late for your appointment, your therapist may refuse to treat you or your therapy time may be reduced.

I certify that any and all information provided by me is true. I have read the information on the front and back of this form. It has been fully explained to me and all of my questions have been answered.

______________________________ ____________

Patient/Guardian Signature **Date**

Physical Therapy Services Privacy Policy

We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. We may disclose your health information to your insurance provider for the purpose of payment or health care operations. We may disclose your health information as necessary to comply with State Workers' Compensation Laws. We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death. As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure. We may disclose your health information in the course of any administrative or judicial proceeding. We may disclose your health information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes. We may disclose your health information to coroners or medical examiners. We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues. We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board. It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public. We may disclose your health information for military, national security, prisoner and government benefits purposes. We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment." We may contact you by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. In the event that we are sold or merged with another organization, your health information/record will become the property of the new owner.

• You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that we are not required to agree to the restriction that you requested.

• You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

• You have the right to inspect and copy your health information.

• You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

• You have a right to receive an accounting of disclosures of your protected health information made by us.

• You have a right to a paper copy of this Notice of Privacy Practices at any time upon request. We reserve the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, we are required by law to comply with this Notice. We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us by calling this office at (316) 858-1177. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days. Complaints about your Privacy rights, or how we have handled your health information should be directed to our Privacy Officer by calling this office at (316) 858-1177. If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within two working days. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

Insurance Questionnaire

Name: ____ Date: ____/_____/_______

1. Is your diagnosis due to an accident or injury? If NO, continue to question 2. YES NO

   If yes, what was the date of the injury? ____/_____/_______

   Cause of Injury? ____

   a. Did this injury occur at work? YES NO

   If yes, have you filed a work compensation claim? YES NO

   b. Did this injury occur due to an accident or incident involving an automobile? YES NO

   If yes, have you filed a claim with the responsible insurer? YES NO

   c. Did this injury occur at a business or a residence other than your own? YES NO

   If yes, is the insurance of the homeowner or business responsible? YES NO

   d. Is this injury being filed with your health insurance? YES NO

2. If you have had a recent surgery for this diagnosis, what date did this occur? ____/_____/_______

3. In the last year, have you had physical therapy at another facility or at home? YES NO

4. Is there an attorney involved with this case? YES NO