



Thank you for choosing Center for Physical Excellence as your physical therapy provider(s).

On the day of your appointment, Please arrive 15 minutes prior to your actual appointment time and bring the following items:

1. Insurance Card(s)
2. Physician's Prescription for Physical Therapy
3. Completed paperwork
4. A form of payment for your applicable out of pocket expenses (we accept Visa, MC, personal checks, and/or cash)

Attire: Please wear comfortable attire and tennis shoes. Your physical therapist will need to access the body part to be treated. Shorts will be necessary for hip, knee, and ankles problems. You may be asked to put a patient gown on for neck, shoulder, or back problems.

We will do everything possible to provide you with a positive experience. You should expect to be treated as an individual and with respect. Your first visit will consist of an individualized examination by a licensed physical therapist. Once your exam is completed, a treatment plan will be developed and will include hands-on contact by your physical therapist. Be prepared to initiate treatment and even exercise on your first visit.

Each staff member has been chosen for their caring attitudes, as well as their professional credentials. They are here to guide you through a pleasant and comfortable experience. From the person that answers the telephone call our technicians that assist us with your care, we are proud of our team. We work hard to provide you with great care and optimal results.

It is our goal that when you come into our office, you feel very good about every aspect of your experience and happy you chose us for your care. Please do not hesitate to request to speak with our office manager, Patricia Fairbanks, with any questions or concerns you may have at any time during the course of your care.

Sincerely,

Laura and Chris Markey
Physical Therapists
Owners of Center for Physical Excellence

Center for Physical Excellence Medical History Form

What are we treating you for? _____

What are your physical therapy goals? _____

Are you or might you be pregnant? Yes No Current Stress Level: None Moderate High

Musculoskeletal System:			Cardiopulmonary System:		
Have you ever had?	Check Box	Year	Have you ever had?	Check Box	Year
Osteoarthritis	<input type="checkbox"/> yes <input type="checkbox"/> no		Heart Surgery	<input type="checkbox"/> yes <input type="checkbox"/> no	
Osteoporosis	<input type="checkbox"/> yes <input type="checkbox"/> no		Pacemaker	<input type="checkbox"/> yes <input type="checkbox"/> no	
Osteopenia	<input type="checkbox"/> yes <input type="checkbox"/> no		Heart Attack	<input type="checkbox"/> yes <input type="checkbox"/> no	
Compression Fracture	<input type="checkbox"/> yes <input type="checkbox"/> no		Angina	<input type="checkbox"/> yes <input type="checkbox"/> no	
Rheumatoid Arthritis	<input type="checkbox"/> yes <input type="checkbox"/> no		Heart Failure	<input type="checkbox"/> yes <input type="checkbox"/> no	
Lupus	<input type="checkbox"/> yes <input type="checkbox"/> no		High Cholesterol	<input type="checkbox"/> yes <input type="checkbox"/> no	
Gout	<input type="checkbox"/> yes <input type="checkbox"/> no		High Blood Pressure	<input type="checkbox"/> yes <input type="checkbox"/> no	
Meniscal Tears	<input type="checkbox"/> yes <input type="checkbox"/> no		Arrhythmia	<input type="checkbox"/> yes <input type="checkbox"/> no	
Herniated Disc-Neck	<input type="checkbox"/> yes <input type="checkbox"/> no		Blood Clot	<input type="checkbox"/> yes <input type="checkbox"/> no	
Herniated Disc-Back	<input type="checkbox"/> yes <input type="checkbox"/> no		Aneurysm	<input type="checkbox"/> yes <input type="checkbox"/> no	
Whiplash	<input type="checkbox"/> yes <input type="checkbox"/> no		Dizziness	<input type="checkbox"/> yes <input type="checkbox"/> no	
Shoulder Dislocation	<input type="checkbox"/> yes <input type="checkbox"/> no		Shortness of Breath	<input type="checkbox"/> yes <input type="checkbox"/> no	
Metal or Plastic Implants?	<input type="checkbox"/> yes <input type="checkbox"/> no (List)		Asthma	<input type="checkbox"/> yes <input type="checkbox"/> no	
Fractures (List) :			Emphysema	<input type="checkbox"/> yes <input type="checkbox"/> no	
Strains / Sprains (List):			COPD	<input type="checkbox"/> yes <input type="checkbox"/> no	
			Pneumonia	<input type="checkbox"/> yes <input type="checkbox"/> no	
			Integumentary System & Other Conditions:		
			Have you ever had?	Check Box	Year
			Skin Cancer	<input type="checkbox"/> yes <input type="checkbox"/> no	
			Skin Ulcers	<input type="checkbox"/> yes <input type="checkbox"/> no	
			Diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no	
Neuromuscular System:			Liver Function Problems	<input type="checkbox"/> yes <input type="checkbox"/> no	
Have you ever had?	Check Box	Year	Hepatitis C	<input type="checkbox"/> yes <input type="checkbox"/> no	
Epilepsy	<input type="checkbox"/> yes <input type="checkbox"/> no		Kidney Failure	<input type="checkbox"/> yes <input type="checkbox"/> no	
Seizures	<input type="checkbox"/> yes <input type="checkbox"/> no		Cancer	<input type="checkbox"/> yes <input type="checkbox"/> no	
Peripheral Neuropathy	<input type="checkbox"/> yes <input type="checkbox"/> no		Clinical Depression	<input type="checkbox"/> yes <input type="checkbox"/> no	
Carpal Tunnel Syndrome	<input type="checkbox"/> yes <input type="checkbox"/> no		Blindness	<input type="checkbox"/> yes <input type="checkbox"/> no	
Brain/Head Injury	<input type="checkbox"/> yes <input type="checkbox"/> no		Deafness	<input type="checkbox"/> yes <input type="checkbox"/> no	
Stroke	<input type="checkbox"/> yes <input type="checkbox"/> no		AIDS	<input type="checkbox"/> yes <input type="checkbox"/> no	
Parkinsons	<input type="checkbox"/> yes <input type="checkbox"/> no		Urinary Incontinence	<input type="checkbox"/> yes <input type="checkbox"/> no	
Balance Problems	<input type="checkbox"/> yes <input type="checkbox"/> no		Fibromyalgia	<input type="checkbox"/> yes <input type="checkbox"/> no	
Frequent Falls	<input type="checkbox"/> yes <input type="checkbox"/> no		Thyroid Imbalance	<input type="checkbox"/> yes <input type="checkbox"/> no	
Other ?					
LIST SURGERIES			LIST MEDICATIONS		

Signature: _____

Date: _____

**Center for Physical Excellence, PC
Notice of Patient Information Practices**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE
USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION.
PLEASE REVIEW IT CAREFULLY.**

Center for Physical Excellence is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION: Center for Physical Excellence uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Center for Physical Excellence may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Center for Physical Excellence may also use or disclose your personal health information without prior authorization for auditing purposes and emergencies. We also provide information when required by law.

For any other situation, Center for Physical Excellence's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Center for Physical Excellence may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS: You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except specifically authorized by you, when required by law in emergency circumstances. Center for Physical Excellence will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS: If you are concerned that Center for Physical Excellence may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Center for Physical Excellence's health information practices or if you have a complaint, please contact the following person:

Christopher Markey, PT
Center for Physical Excellence
3117 Stillwater Drive
Prescott, AZ 86305
Telephone: 928-442-0005 Fax: 928-442-0660

Center for Physical Excellence Patient Information Consent Form

I have read and fully understand Center for Physical Excellence's Notice of Information Practices. I understand that Center for Physical Excellence may use or disclose my personal information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrated operations related to treatment or payment.

I also understand I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Center for Physical Excellence will consider requests for restriction on a case by case basis, but does not have to agree to request for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Center for Physical Excellence Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Signature

Date

Center for Physical Excellence Cancellation and No-Show Appointment Policy

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic, because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

- We require **24 hours** notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible. (In some cases, this may not work since some forms of treatment do not work well if given two sequential days.)
- There will be a **\$50.00** charge for appointment cancellation without 24 hour notice. This charge will not be covered by insurance, but will have to be paid by you personally.
- For **Workers Compensation** patients, documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.
- You may need to see a therapist other than the one who normally treats you if you re-arrange your appointment. All of our therapists are experienced professionals, and they study your patient chart, so you will be in good hands.
- Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. Either condition can seem to be a reason not to come in: a) you're feeling worse and think the treatment is not working or, b) you're feeling better and it's a great day for hiking. Neither of these conditions is legitimate as a reason not to come. If you're in pain, come in and get it fixed. If you're out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem, educate you so you won't re-injure yourself, etc.

When you do not show as scheduled, three people are hurt: you because you don't get the treatment you need as prescribed by the doctor and /or PT; the therapist who now has a space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice.

If you do not show for three appointments during the course of your therapy or if you fail to return repeated telephone calls from our staff; your referring physician or case manager will be notified. All remaining appointments will subsequently be removed from your schedule.

Please co-operate with us in this regard. We're looking forward to working with you.

I have reviewed this policy with a member of CPE staff. I understand and agree to abide by this policy.

Patient Signature

Date

CPE Staff Signature

Date

**Center for Physical Excellence, PC
Financial Policy**

FOR ALL PATIENTS: Please be assured that your health is our primary concern. The following office policies are outlined for your benefit in order to avoid possible areas of confusion. The office personnel are available to assist you if you have any questions.

Center for Physical Excellence, PC accepts assignment for Medicare. If your insurance plan has a co-payment or a deductible that has not been fulfilled, the payment of the co-payment and/or the amount of the remaining deductible is due at the time of service.

As a courtesy to you, this office will bill your insurance. We will also bill your Medicare secondary insurance if applicable. However, any and all charges not covered by your insurance(s) are due and payable without delay, unless prior arrangements are made with this office.

Our office will also verify the presence of insurance coverage on your primary insurance; however, you are responsible for knowing the benefits and restrictions of your insurance policy. At your request, we will assist you with obtaining pre-certification or pre-authorization required by your insurance.

Any special requirements for services, pre-certification for services, or pre-authorization are ultimately your responsibility.

I have read and understand the above Financial Policy and hereby acknowledge that any and all medical bills, collection fees on my account, or lawyer's fees incurred due to my delinquent payments are my personal responsibility.

I hereby authorize Center for Physical Excellence to perform rehabilitation services to myself/child and authorize them to release my therapy records (including my evaluations, treatment records and progress notes to my physician, insurance carrier, and/or other named institutions).

I authorize payments of medical benefits to Center for Physical Excellence for any medical care rendered to myself or to my dependents. I understand that I am responsible for any amount not covered by my insurance.

I acknowledge all of my patient information is complete and true. I also understand that overdue balances may incur additional charges. I will bear the cost of collection and/or court costs/legal fees should this be required.

Signature: _____ Date: _____

Witness: _____ Date: _____

Emergency Contact Information

Name: _____ Telephone: _____

Medicare Out-Patient Physical Therapy Services

As of January 1, 2010, Medicare has reinstated the cap on out-patient physical therapy services provided in a private practice setting. The yearly maximum as of January 2011 is **\$1870.00** per calendar year (an increase from the previous cap of \$1860.00) for combined physical therapy and speech-language pathology services. Medicare will pay 80% of their acceptable charges after your deductible has been met.

Your secondary or supplemental insurance carrier (if applicable) will then pay a portion of the remaining 20%; depending upon your individual plan benefits. As a courtesy to you, Center for Physical Excellence, PC will bill your secondary carrier for the remaining 20% of Medicare allowable charges. Any balance remaining after secondary reimbursement will be your responsibility.

In order for physical therapy services to be covered by Medicare B:

1. It must be demonstrated that the judgment, skills, and knowledge of a qualified physical therapist are necessary for the patient to progress, and
2. There must be an expectation that the patient will improve significantly in a reasonable and generally predictable period of time.

Medicare may pay for infrequent re-evaluation visits but will NOT pay for maintenance level therapy, modalities, or exercises that can be performed at home.

After completing your evaluation or re-evaluation; if your physical therapist believes that additional physical therapy services would not meet the requirements for Medicare reimbursement, it is then your decision with the referring physician's approval to continue physical therapy services. At that time you will have the option of receiving physical therapy in a hospital based setting or sign an Advanced Beneficiary Notice and assume full financial responsibility for the remainder of your care to continue at Center for Physical Excellence.

Please sign below to indicate you have read and understand this notice and authorize Center for Physical Excellence, PC to hold you financially responsible for all physical therapy charges incurred after your physical therapist deems services to be non reimbursable by Medicare.

Signature: _____ Date: _____

Medicare Requirements for Physician Follow-up

Out-patient physical therapy services may be furnished to a Medicare beneficiary who is under the care of a physician. There must be evidence in the patient's clinical record that he/she has been seen by their physician. After the initial physical therapy treatment, your physical therapist is responsible for obtaining an updated plan of care signed by your physician after 30 days in order to continue. The patient, however, must be seen again by their referring physician after 60 days of physical therapy (if further services are needed). At that time, the physician will recertify continued physical therapy if appropriate.

Signature: _____ Date: _____

Date last seen by physician: _____

Physical Therapy & Home Health Care

Medicare will not cover outpatient physical therapy costs if you are currently receiving any home health care services. Also, if you have started a physical therapy regime and then begin using home health care services, Medicare will deny payment for your physical therapy.

I understand Medicare's coverage of physical therapy services will be denied if I am under the care of a Home Health Care Service. By signing this form I am acknowledging that I am not receiving home health care services of any kind.

During the course of my physical therapy treatment I will inform Center for Physical Excellence prior to any home health care services being received or initiated.

Signature _____

Date: _____