Agility
Physical Therapy
and
Sports Medicine

7375 E. Orchard Rd Suite 200|Greenwood Village, CO 80111
(303)773-0771

Physical Therapy Consent

1. I _____ give permission for APTASM to provide evaluation, diagnoses and treatment for my current injuries/ailments.
2. _____ I understand that I play a pivotal roll in my healing process and I must do the exercises and home program that are provided by my care provider. I Must also attend all scheduled appointments or incur a **$75 fee if 24hr notice is not given and charged to card on file**
3. _____I understand that I am responsible for my portion of deductible, co-pay or co-insurance that my health insurance company tells my provider I am responsible for and I will **PAY IN A TIMELY MANNER** or be subject to interest charges and Collection fees. I also understand that in the event **my Insurance takes longer than 90 days to pay I will be billed** the best of Knowledge in-Network Rate for APTASM participating rate of Insurance plans. I Hereby agree to pay all collection fees and Attorney fees in the event that my account is assigned to collections to enforce payment of this debt.
4. _____ I understand that if I have a check returned I will be responsible for any bank charges and a$40 fee for service and no longer allowed to pay by check.
5. _____ I understand that I have the right to refuse billing my insurance company and pay a cash pay rate of **$85 for 30 minutes/Follow Ups; $140 for 60 minutes/Exams**, Or I may pay **$140 for the initial** session and an Up Front total of **$480 for 6 sessions or $750 for 10 sessions**
6. _____ I understand I have the right to refuse and specific type of treatment and agree to communicate with my care provider those desires.
7. _____ I give APTASM permission to contact any of my other care providers regarding my injuries and obtain prior medical records so that the best care possible may be provided for me by my PT.

Permission to Leave Messages

I give permission for a representative of Agility Physical Therapy and Sports Medicine to leave a message in any of the following locations:

_____ Home: _____

_____ Cell: _____

_____ Email: _____

Patient Name: _____

Patient Signature: _____Date: _____

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Financial Policy

1. PAYMENT is expected at the time of your visit. We will accept cash, check, or credit card (2% fee for each transaction). Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company including fees for needling at $3 per session and cold laser treatment at $18/session. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of you visit. We do ask for a copy of an ID card of license due to the many cases of identity theft in the news lately. (Please do not be offended!) We also require Insurance card at first session or you will be billed the cash rate.

Agility Physical Therapy and Sports Medicine **Will keep a card on File in protected space through encrypted data transfer for each patient. This credit card on file will be charged for all no-shows and balances over 90days.**

2. INSURANCE We are participating providers with several insurance plans. We will file all of these insurance claims. **Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full.** If your insurance company does not pay the practice within a reasonable period of time (90days), you will be billed. If we later receive payment for your insurer, we will refund any overpayment to you. If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, **our staff cannot guarantee your eligibility and coverage.** Be sure to check with you insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement form our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy. Patients who insist on "day of" urgent/emergent scheduling or care after hours or on days the clinic is closed will be assessed an additional urgent care or after hours fee. These fees will be billed to you at the time if service. We take liens on a case by case basis and charge a $25 fee for each D.O.S. at time of service.

3. LATE CHARGES of 22% annually will be applied to all patient balances 60 days old or greater.

4. RETURNED CHECKS will incur a $40.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $30 service fee and collections action. All bad checks written to this office are subject to collections and will be prosecuted in ARAPAHOE County.

5. ACCOUNTING PRINCIPALS: Payment and credits are applied to the oldest charges first, except for insurance Payments, which are applied to the corresponding dates of service.

6. FORMS FEES: Completing insurance forms, copying medical records, etc. requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges are $10 per occurrence plus and applicable postage or notary fees. Postage is additional and payment is required in advance. Copying fees for Medical Records when requested by the patient are as follows: $14.50 for the first ten (10) pages and $0.50 per page 11-40 and $0.33 per 41+. We have 15 days to make said copies and these 15 days will commence after payment for copying has been received and

after patient has signed this form authorizing records' release. 3rd parties requesting copies have a different fee and you can find that at Health Facilitates and Emergency Medical Services Division website.

7. CANCELLATIONS OR MISSED APPOINTMENTS: If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a $75 missed appointment fee. **10-15 Minutes late counts as a No-Show** unless the appointment time after you is open and or another provider can care for you within the day or week (2 sessions per week are kept if 2 were scheduled.)

8. RESPONSIBILITY FOR PAYMENT: I understand that I, personally, am financially responsible to Agility Physical Therapy and Sports Medicine for charges not covered by My insurance company for ANY reason.

9. ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign, transfer, and set over directly to Agility Physical Therapy and Sports Medicine sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to me or my dependent in said clinic. I authorize Agility Physical Therapy and Sports Medicine to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Agility Physical Therapy and Sports Medicine. I authorize Agility Physical Therapy and Sports Medicine to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

10. COLLECTION FEES: I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

11. DIVORCED PARENTS of PATIENTS: By signing below, the adult who signs a minor child into our practice on the first day of service **accepts responsibility for payment**. This office **does not promise to send bills or records to the other parent/guardian for issues of payment or communication**. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____ _____

Signature of Patient (or Guarantor, if applicable) Date

_____

Please print the name of the patient and their Date of Birth

_____

address for communication:

_____ _____ _____

city State Zip

Patient Health Questionnaire - PHQ

ACH Group, Inc - From PHq-202

ACH Group Use Only rev 9/11/2002

Patient Name _____ ***Date*** _____

1. Describe your symptoms _____

_____

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

- ☐ Constantly (76 - 100% of the day)
- ☐ Frequently (51 - 75% of the day)
- ☐ Occasionally (26 - 50% of the day)
- ☐ Intermittently (0 - 25% of the day)

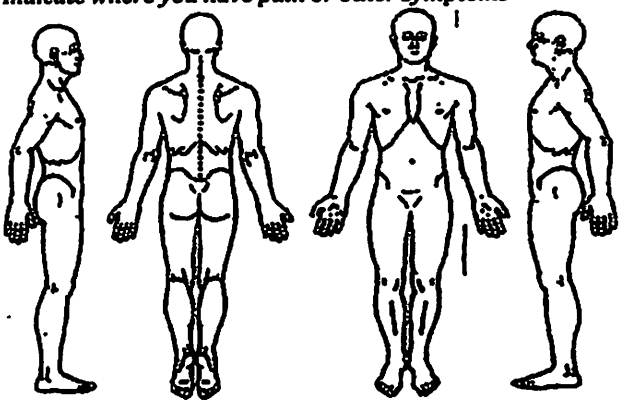
3. What describes the nature of your symptoms

- ☐ Sharp
- ☐ Dull ache
- ☐ Numb
- ☐ Shooting
- ☐ Burning
- ☐ Tingling

4. How are your symptoms changing?

- ☐ Getting Better
- ☐ Not Changing
- ☐ Getting Worse

Indicate where you have pain or other symptoms



5. During the past 4 weeks:

None *Unbearable*

a. Indicate the average intensity of your symptoms ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐1

b. How much has pain interfered with your normal work (including both work outside the home and housework)

☐Not at all ☐A little bit ☐Moderately ☐Quite a bit ☐Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities? *(like visiting with friends, relatives, etc)*

☐All of the time ☐Most of the time ☐Some of the time ☐A little of the time ☐None of the time

7. In general would you say your overall health right now is...

☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

8. Who have you seen for your symptoms?

☐No One ☐Medical Doctor ☐Other
☐Chiropractor ☐Physical Therapist

b. What treament did you receive and when?

a. What tests have you had for your symptoms and when were they performed?

☐Xrays *date:* ☐CT Scan *date:*
☐MRI *date:* ☐Other *date:*

9. Have you had similar symptoms in the past? ☐Yes ☐No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

☐Xrays *date:* ☐CT Scan *date:*
☐MRI *date:* ☐Other *date:*

10. What is your occupation

☐Professional/Executive ☐Laborer ☐Retired
☐FT Student ☐Homemaker ☐Other
☐Tradesperson ☐White Collar/Secretarial

a. If you are not retired, a homemaker, or a student, what is your current work status?

☐Full-time ☐Self-employed ☐Off Work
☐Part-time ☐Unemployed ☐Other

Patient Signature _____ ***Date*** _____

Patient Health Questionnaire - page 2

ACH Group, Inc - From PHq-202

ACH Group Use Only rev 9/11/2002

Patient Name ***Date***

What type of regular exercise do you perform? ☐None ☐Light ☐Moderate ☐Strenuous

What is your height and weight? **Height** ____ ____ ____ **Weight** ____ ____ ____ lbs

Feet *Inches*

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past, if you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present
☐	☐ Headaches		☐	☐ High Blood Pressure		☐	☐ Diabetes
☐	☐ Neck Pain		☐	☐ Heart Attack		☐	☐ Excessive Thirst
☐	☐ Upper Back Pain		☐	☐ Chest Pains		☐	☐ Frequent Urination
☐	☐ Mid Back Pain		☐	☐ Stroke			
☐	☐ Low Back Pain		☐	☐ Angina		☐	☐ Smoking/Use Tobacco Products
						☐	☐ Drug/Alcohol Dependence
☐	☐ Shoulder Pain		☐	☐ Kidney Stones			
☐	☐ Elbow/Upper Arm Pain		☐	☐ Kidney Disorders		☐	☐ Allergies
☐	☐ Wrist Pain		☐	☐ Bladder Infection		☐	☐ Depression
☐	☐ Hand Pain		☐	☐ Painful Urination		☐	☐ Systematic Lupus
			☐	☐ Loss of Bladder Control		☐	☐ Epilepsy
☐	☐ Hip/Upper Leg Pain		☐	☐ Prostate Problems		☐	☐ Dermatitis/Eczema/Rash
☐	☐ Knee/Lower Leg Pain					☐	☐ HIV/AIDS
☐	☐ Ankle/Foot Pain		☐	☐ Abnormal Weight Gain			
			☐	☐ Loss of Appetite		*Females Only*	
☐	☐ Jaw Pain		☐	☐ Abdominal Pain		☐	☐ Birth Control Pills
			☐	☐ Ulcer		☐	☐ Hormonal Replacement
☐	☐ Joint Swelling/Stiffness		☐	☐ Hepatitis		☐	☐ Pregnancy
☐	☐ Arthritis		☐	☐ Liver/Gall Bladder Disorder		☐	☐
☐	☐ Rheumatoid Arthritis						
			☐	☐ Cancer		*Other Health Problems*	
☐	☐ General Fatigue		☐	☐ Tumor		☐	☐
☐	☐ Muscular Incoordination					☐	☐
☐	☐ Visual Disturbances		☐	☐ Asthma		☐	☐
☐	☐ Dizziness		☐	☐ Chronic Sinusitis		☐	☐

Indicate if an Immediate family member has had any of the following:

☐Rheumatoid Arthritis ☐Heart Problems ☐Diabetes ☐Cancer ☐Lupus ☐____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized

_____ _____ _____

_____ _____ _____

Patient Signature ***Date***

Doctor's Additional Comments

_____

_____

_____

Doctor's Signature ***Date***

Lower Extremity Functional Index

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb problem for which you are currently seeking attention. Please provide an answer for each activity.

Today, do you or would you have any difficulty at all with:

(Circle one number on each line)

Activities	Extreme Difficulty or unable to perform activity	Quite a bit of difficulty	Moderate difficulty	A little bit of difficulty	No difficulty
a. Any of your usual work, housework or school activities.	0	1	2	3	4
b. Your usual hobbies, recreational or sporting activities	0	1	2	3	4
c. Getting into or out of the bath.	0	1	2	3	4
d. Walking between rooms.	0	1	2	3	4
e. Putting on your shoes or socks.	0	1	2	3	4
f. Squatting.	0	1	2	3	4
g. Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
h. Performing light activities around your home.	0	1	2	3	4
i. Performing heavy activities around your home.	0	1	2	3	4
j. Getting into or out of a car.	0	1	2	3	4
k. Walking 2 blocks.	0	1	2	3	4
l. Walking a mile.	0	1	2	3	4
m. Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
n. Standing for 1 hour.	0	1	2	3	4
o. Sitting for 1 hour.	0	1	2	3	4
p. Running on even ground.	0	1	2	3	4
q. Running on uneven ground.	0	1	2	3	4
r. Making sharp turns while running fast.	0	1	2	3	4
s. Hopping.	0	1	2	3	4
t. Rolling over in bed.	0	1	2	3	4
COLUMN TOTALS					

Score variation ± 6 LEFTS points
MDC & MCID = 9 LEFS points

Score _____/80