PATIENT INFORMATION FORM

ZOOM Physical Therapy & Wellness
The Right Path to Better Health

Name_____ Date of Birth _____/_____/_____ Sex: ❑M ❑F

Address_____City _____State _____Zip_____

Home # _____ Cell # _____E-mail _____

How did you hear about us? ❑ Former Patient ❑ School ❑ Facebook ❑ Instagram ❑ Google ❑ Golf ❑ Physician ❑ Advertisement Other:_____

Are you currently receiving Home Health Services? ❑ Yes ❑ No * Your insurance will not cover your services if you have home health

How do you prefer to be reminded of your appointment? ❑ Phone Call ❑ Text Message ❑ Email

Emergency Contact _____Relationship_____ Phone_____

Employer/School _____

Occupation_____Work#_____ SS#_____

PHYSICIAN INFORMATION

★**REFERRING** Physician:_____ Phone_____

If Referring physician is NOT your General/Primary Physician, please provide name:_____

Date of Injury _____/_____/_____ Is this an approved Workers Comp Injury? ❑yes ❑ no

Is this visit a result of an Auto Accident? ❑ Yes ❑ No

INSURANCE INFORMATION

PRIMARY Insurance Company_____ Name of Policy Holder _____

ID#_____ Group#_____ Phone# _____

Patient Relation to Policy Holder: ❑ Self ❑ Spouse ❑ Child Subscribers Date of Birth: _____/_____/_____

SECONDARY Insurance Company_____ Name of Policy Holder _____

ID#_____ Group#_____ Phone# _____

Patient Relation to Policy Holder: ❑ Self ❑ Spouse ❑ Child Subscribers Date of Birth: _____/_____/_____

TERTIARY Insurance? ❑ Yes ❑ No

WORKMANS COMPENSATION ONLY

Workman's Compensation (employer's name) _____ Phone_____

Address _____ City_____ State_____ Zip _____

Claims Adjustor Name _____ Phone _____ Claim#_____

Claims Adjuster Insurance Company Name _____

Rehab Nurse Name _____Phone_____Fax_____

Nurse Case Management Co. Name _____Phone _____ Fax _____

MEDICAL INFORMED CONSENT

I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and/or physician, I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the result of the services at Zoom Physical Therapy and Wellness. It is this clinic's sincere intent to educate me on every process, from billing to treatment and eventually discharge from services. Therefore, if techniques that are being used are not understood, it is my responsibility to obtain a clearer understanding of what the therapist's objectives and outcomes are, and how he/she is trying to achieve them.

Patients Initials:_____

ASSIGNMENT AND RELEASE

This is a direct assignment of my rights and benefits under this policy. I hereby authorize my insurance benefits be paid directly to Zoom Physical Therapy and Wellness for the care I receive, and I understand that I am financially responsible for non-covered services. I understand that if Zoom Physical Therapy and Wellness does not contract with my insurance company, I will be responsible for the difference between what is charged and what my insurance pays. I also authorize the physician and /or Zoom Physical Therapy and Wellness to release any information necessary in order to process this claim. All of the information provided is correct and true to the best of my knowledge. I understand that I am responsible for all charges incurred at Zoom Physical Therapy and Wellness.

Patients Initials:_____

HIPPA

In compliance with HIPAA regulations I authorize the following individuals to receive information regarding the billing of my account or medical records access.

_____	_____	_____
Name/Relationship	Name/Relationship	Name/Relationship
❑ Billing ❑ Medical records	❑ Billing ❑ Medical records	❑ Billing ❑ Medical records

NOTICE OF PRIVACY PRACTICE & HIPPA

I acknowledge receipt of Zoom Physical Therapy and Wellness's ***Notice of Privacy Practices & HIPPA.*** Zoom Physical Therapy will use or disclose my PHI for the purposes of carrying out **treatment, payment and health care operations**. The Notice of Privacy Practices & HIPPA provides detailed information about how the practice may use and disclose my confidential information. I understand Zoom Physical Therapy and Wellness has reserved the right to change its privacy practices that are described in the Notice. I give my consent for Zoom Physical Therapy and Wellness to notify me of new facilities or services. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to Zoom Physical Therapy and Wellness.

Patients Initials:_____

⬇ PLEASE PRINT & SIGN

_____	_____	_____
Patients Name	Patients Signature	Date

FINANCIAL POLICY

As a courtesy to our patients, we will verify your insurance coverage and benefits (*Verification is only a **quote**) as well as file therapy claims for you, however we do not accept the responsibility for settling the claim with your carrier.

- **Copays, Co-ins and/or Deductibles are due at the time of service.**
- A credit card is required to be kept on file for all payments or no shows. Your account will be charged only as appropriate. Your credit card will remain in effect until you notify us in writing that you wish to cancel. You must be an authorized user on the credit card on file. Please review our Financial Policy on the wall for further information.
- **No Show appointments: We currently have a *$25 NO SHOW* fee for appointments missed prior notice. We have a limited number of appointment slots each day and we hope you recognize the value for yourself and other patients as well. Late Policy:** If you are more than 10 minutes late to your appointment, you may be rescheduled or asked to wait for the next available time slot.
- Please give us 24 hours notice for any Cancellations or the NO SHOW fee will apply. If you have questions about your bill, please speak with our front office.

Patients Initials:_____

PHOTO AND VIDEO WAIVER

I grant Zoom Physical Therapy and Wellness permission to use my likeness in photograph(s)/video in any and all of its publications and in any and all other media, whether now known or hereafter existing, controlled by Zoom Physical Therapy and Wellness in perpetuity, and for other use by Zoom Physical Therapy and Wellness or it's employees including but not limited to educational purposes. I will make no monetary or other claim against Zoom Physical Therapy and Wellness for the use of the photograph(s)/video.

Patients Initials:_____

NON-COVERED SERVICES

The services that are included under the Non-Covered Services statement may or may not be an item that your Physical Therapist determines to be a Medical Necessity for your current diagnosis. It is common for 1 or 2 of the items listed below to be used during our usual Physical Therapy programs. It is recommended that during home exercises and self-treatments that you simulate the same movements as in our clinic as close as possible. Most often used, is the charge for a one -time Theraband charge. As you progress with your treatment, we will be giving you more than the 1 quantity of Theraband to use for your home exercises; your one-time payment will include ALL further pieces.

*Any additional items recommended by your therapist are optional and will **not** be billed automatically. These* recommendations will be discussed with you before hand.

NON-COVERED ITEMS AVAILABLE FOR PURCHASE

- Theraband/Theratubing $5
- PRI Ball $5 Shoulder Pulley $20
- TherBand Foot Roller $14
- Strassburg Sock $35
- Sombra $12-$15
- Gel Ice Pack – Cervical $20
- Gel Ice Pack – Oversized $25
- Moist Heating Pad $30
- Spider Tech Tape $15
- TENS Unit with pads $90
- Electrodes $5
- Subzero $12-$30
- Exercise Programs FREE
- Balloons FREE

I HAVE READ AND UNDERSTOOD THAT CERTAIN ITEMS ARE NOT COVERED UNDER INSURANCE AND MAY BE AVAILABLE FOR PURCHASE IF SUGGESTED BY THE PHYSICAL THERAPIST AT THE COST ABOVE.

_____ _____

Patients Signature Date

PRE-EXAM FORM: In order to evaluate your condition fully, please be as accurate as possible. Thank you.

PATIENT NAME: _____ AGE: ___ DOB: ___/____/_____ ❑ Female ❑ Male

OCCUPATION: _____ ARE YOU WORKING NOW? ❑ Yes ❑ No

1.	Where is your pain/problem?	
2.	What caused your pain/problem?	
3.	Approximately when did it start?	
4.	List ONE ACTIVITY you are unable to do, that you absolutely want to be able to do again:	
5.	Have you ever had this same (or similar) pain/problem before?	❑ Yes (If yes, when and describe?) ❑ No
6.	In your understanding, what do you think will make it better?	
7.	How optimistic are you that you'll get better? (circle one)	Not at All Mildly Optimistic Fairly Very Optimistic Extremely
8.	What are some potential obstacles to you getting better?	
9.	Over the next 30-days, how many hours per week will you commit to getting better?	
10.	What are you expecting from therapy?	
11.	On the scale, circle your worst pain level in the past couple of days:	*Mild* *Moderate* *Severe* 0 . . . 1. . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10
12.	List any medications you are taking:	
13.	List all past surgeries with dates:	
14.	List all medical conditions you have (or were told you have):	

I understand that my candidacy for a rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The doctor/therapist will determine whether or not I am a viable candidate for a rehabilitation program and that my approval into their program is not guaranteed.

Patient Signature (or guardian): _____ Date: _____

CREDIT CARD AUTHORIZATION AND FINANCIAL POLICY AGREEMENT

Zoom Physical Therapy & Wellness

At Zoom Physical Therapy & Wellness, we strive to make your healing journey smooth and efficient. By securely storing your credit card information using industry-standard encryption and tokenization (PCI DSS compliant), we can streamline billing and focus on your recovery. This allows seamless processing of payments and remaining balances after insurance claims reducing administrative costs.

PATIENT INFORMATION

Patient Name: _____ Phone: _____

Billing Address: _____ Email: _____

CARD DETAILS ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name: _____ Last 4 Digits: _____ (**Last 4 digits only**) (Full card data, expiration date, and CVV will be captured during initial transaction)

FINANCIAL POLICY AND TERMS

By signing below, I understand and agree to the following:

1. Payment Terms:
   - I am responsible for all charges for services provided.
   - Co-pays, co-insurance, and deductibles are due at time of service and are provided to me as an ***ESTIMATE***. Even though we collect at the time of service you could still have a balance at the end of your care once all claims have been processed by your insurance. **This balance is decided by your insurance company, not our office.**
   - Any Remaining balances ***AFTER*** insurance processes your claims, if any, will be charged to your stored card **after 1 invoice** has been sent to you for payment. **We can always set up a payment plan if needed**. Our invoices can be sent by text or email.
   - Email notification will be sent before processing any remaining balance. If you would prefer a text message please add phone number _____
   - The $50 billing fee will be waived with a credit card on file. **Any credit after all claims have been processed will be returned to the patient including this fee.**
2. I authorize Zoom Physical Therapy & Wellness to:
   - Store my card information securely
   - Charge my card for outstanding balances, unpaid services, late fees, or no-show fees
   - Process authorized supplies or services **I agree to purchase**
3. Additional Terms:
   - I will update card information if it changes
   - **I may revoke this authorization with written notice *AT ANY TIME***
   - I have the right to dispute charges and request receipts at any time.
   - I will review my Explanation of Benefits (EOB) that I receive from my insurance company
   - If sent to collections, I'm responsible for collection agency fees (up to 35%), attorney fees, and court costs
   - Written notice will be provided **before** sending to collections
4. Acknowledgment:
   - I am an authorized user of this card
   - I have read and understood all terms and asked any questions
   - This authorization remains effective until cancelled in writing
   - All transactions comply with U.S. law

Patient's Name (Print): _____

Cardholder's Signature: _____ Date: _____