



Thank you for choosing Living Well Therapy, LLC for your Physical Therapy needs!

We are here to serve you and we strive to provide the best possible physical therapy services.

We would like to introduce you to our clinic and cover some things as close to your first visit as possible. Our office manager is Sheree' Vance. Sheree' is available at 541 312 2004 for any insurance authorization or scheduling questions that you may have. You also can email her at info@livingwelltherapy.com if this is more convenient for you. If you have billing questions, please call our billing specialist, South Coast Billing directly at 888 406 1986. We are open Monday through Thursday 8am- 6pm in Bend and Friday 8am - 1pm by appointment.

Patients are typically seen 2-3 times per week initially with less frequent visits and less one on one time with their Physical Therapist as the patient recovers. Appointments are typically an hour in duration with about half of this time spent one on one and about half spent supervised with other recovering patients in the treatment area. The first visit is typically longer than one hour. Please inform us of the date and time a week in advance of any follow-up visits with the person who referred you so that we can give you the best care and provide a progress note to the person who referred you. We do our best to stay on time and minimize interruptions during your visit but some may be necessary. For example, taking an important phone call including one from a physician office may be necessary to ensure the best care of you and our other patients. To maintain patient confidentiality, family members are not permitted in the treatment area if there are other patients being treated.

Depending on your diagnosis and progress, some items of medical equipment may be helpful to assist with your recovery. Equipment includes pulleys, back and neck cushions, exercise balls, exercise band, massage tools, and a variety of pain relief creams and lotions. You are welcome to obtain the equipment where ever you like. As a convenience to our patients, we do stock or can order the majority of these items at wholesale prices but mark them up to retail to cover shipping, inventory, and shrinkage costs. We do request you return any item in like new condition if you are not fully satisfied so that we can provide you an immediate refund. In order to assist with total patient health and wellness, we now offer the leading medically supervised weight management program and maintain a financial interest in this and most other service provided at the clinic.

The cost of your visit can vary depending on what treatments you need that day. As a convenience to you, our office will bill your insurance company and answer any questions since many insurance plans can be difficult to understand. If we are "contracted" with your plan, you are responsible for any co-payments and cost shares paid at the time of service. There are some "non-contracted" plans that require full payment in advance. We do accept Visa and MasterCard and offer a 15% discount for same day payment of services. If you have a credit, it will be reimbursed at the end of your treatment. Your insurance pays only what they consider usual and customary and this may be less than the actual cost at our or other local clinics. If we are not contracted with your plan we are not obligated to accept that amount, therefore the full cost becomes your responsibility. If you are paying on a cash basis or earning a low income, we do have a hardship form available to determine if you qualify for discounted services. The amount must be paid at the time of service. We send statements once a month. The statement reflects the cost of the service, the amount paid by you and/or your insurance, and what is due now.

An example of this is:

- If we charge \$100.00 for a service and your insurance only pays \$70.00 you are responsible for the remaining \$30.00.
- Initial evaluation is \$135.00 (An evaluation is required by law).
- Any other services cost between 25.00-55.00 each.
- The first service can normally be \$250.00-350.00.
- Subsequent treatments vary between \$50.00-250.00.
- A \$50.00 no show/cancellation without 24-hour notice.

We hope this information has been helpful. Please feel free to call Sheree if you have any questions. We look forward to serving you and we believe that you will be pleased with your care. Therefore, the highest compliment you can give us is the referral of your friends, family, and co-workers.

Patient Signature _____ Date _____

LIVING WELL THERAPY, LLC
PATIENT INTAKE AND CONSENT FORM

Last name: _____ S.S.# _____ - - _____ Today's Date: _____

First name: _____ Age: _____

Address: _____ Date of Birth _____

City: _____ State: _____ Zip: _____ Sex: M F

Email: _____ Marital Status: S M D W

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of injury/Onset: _____ Accident Related: YES NO

Injury Area: _____ If Accident: AUTO WORK OTHER

Nature of Accident: _____

Responsible Party: _____ Relationship to Responsible Party: _____

Address: _____ Phone #: _____

Employer: _____ Occupation: _____

Address: _____ Phone #: _____

City/State/Zip: _____ Contact: _____

Referring Physician: _____ Phone #: _____

Primary Insurance: _____ Insured Name: _____

Group #: _____ Address: _____

ID #: _____ City/State/Zip: _____

Relationship to Insured: _____ Phone #: _____

Secondary Insurance: _____ Insured Name: _____

Group #: _____ Address: _____

ID #: _____ City/State/Zip: _____

Relationship to Insured: _____ Phone #: _____

Emergency Contact: _____ Phone #: _____

How did you become aware of our office? _____

Have you received any prior outpatient physical, occupational, or speech therapy services or home health services in the current calendar year? YES NO If yes, please indicate services you received: _____

CONSENT TO TREATMENT: I consent to rehabilitation and related services at *Living Well Therapy, LLC* _____ Please initial: _____

LIABILITY: I know and agree that *Living Well Therapy, LLC* is not responsible for loss or damage to personal valuables: _____

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to *Living Well Therapy, LLC* and authorize release of any medical records necessary to process medical claims. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment: _____

NOTICE OF PRIVACY: I acknowledge receipt of Notice of Privacy Practices: _____

I understand that if I have Medicare insurance with a supplemental insurance and Medicare does not do the automatic crossover, that I am responsible for my (20%) cost share at the time of services. I can then bill my secondary insurance for reimbursement _____

I understand that *Living Well Therapy, LLC* does charge interest in the amount of (1 ½%) per month on account balances greater than 30 days: _____
I understand that *Living Well Therapy, LLC* does charge a \$25.00 rebilling fee for each month a statement is sent to me requesting payment after 60 days. _____

I certify that all of the information provided herein is true and correct: _____

Patient/Guardian Signature: _____ Date: _____

LIVING WELL THERAPY, LLC

HEALTH HISTORY

PATIENT'S NAME

Answer all questions by circling Yes (Y) or No (N)

- 1. Are you in good health? Y N
2. Has there been any change in your general health in the past year? Y N
3. Date of last physical exam
4. Are you now under a physician's care for a particular problem? Y N
5. Have you ever had any serious illnesses, operations or hospitalizations? If so, describe: Y N
6. Height Weight kg
7. What are we seeing you for?
8. What increases your symptoms?
9. What decreases your symptoms?
10. Are you hot or cold when others are not? Y N
11. Have you recently lost or gained significant amount of weight? Y N
12. Do you bruise easy? Y N
13. DO YOU HAVE OR HAVE EVER HAD:
A. Problems with joints? Y N
B. Phlebitis or blood clots in the veins of your legs? Y N
C. Depression? Y N
D. Numbness or tingling? Y N
E. Headaches? Y N
F. Rheumatic Fever or Rheumatic Heart Disease? Y N
G. Congenital Heart Disease? Y N
H. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker)? Y N
I. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)? Y N
J. Seizures, Convulsions, Epilepsy, Fainting or Dizziness? Y N
K. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion? Y N
L. Liver Disease (Jaundice, Hepatitis)? Y N
M. Kidney Disease? Y N
N. Diabetes? Y N
O. Thyroid Disease (Goiter)? Y N
P. Arthritis? Y N

DATE

All responses are kept confidential

- Q. Stomach Ulcers or Colitis? Y N
R. Glaucoma? Y N
S. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)? Y N
T. Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grind or clenched teeth? Y N
U. Sinus or Nasal problems? Y N
V. Any disease, drug or transplant operation that has depressed your immune system? Y N
W. Have you been told you snore loudly or have you been diagnosed with obstructive sleep apnea? Y N
14. ARE YOU USING ANY OF THE FOLLOWING:
A. Anticoagulants (Blood Thinners)? Y N
B. Aspirin or drugs such as Motrin, Aleve, ibuprofen? Y N
C. Steroids (Cortisone, etc.)? Y N
D. Insulin or Oral Anti-Diabetic drugs? Y N
E. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
F. Have you used any street drugs? Y N
G. Please list any and all medications taken, including prescription medications, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:
H. Are you using or have you ever used bisphosphonates (bone density medications), such as Fosamax, Boniva, Actonel, Evista or Novartis? Y N
I. Are you using or have you ever used chemotherapy medications such as IV Aredia or Zometa? Y N
15. ARE YOU ALLERGIC TO ANY PRESCRIPTION OR OVER THE COUNTER DRUGS, FOODS OR SUPPLEMENTS? PLEASE LIST:
16. Do you smoke or chew tobacco? Y N How much per day?
17. Is there any past history of Alcohol or Chemical dependency or Emotional Disorder that may affect the care we provide you? Y N
18. How much alcohol do you drink?
19. Do you have any other disease, condition or problem not listed above that you think the doctor should know about? Y N
20. Do you wish to talk to the doctor privately about anything? Y N
21. FOR WOMEN ONLY
A. Are you pregnant or is there any chance you might be pregnant? Y N
B. Are you nursing? Y N
22. WHO IS YOUR PHYSICIAN?

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I certify that I have read and I understand the questions above. I acknowledge that I have had the opportunity to discuss my Health History. My questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his staff, responsible for any errors or omissions that I have made in the completion of this form.

Date

Signature of person completing Health History

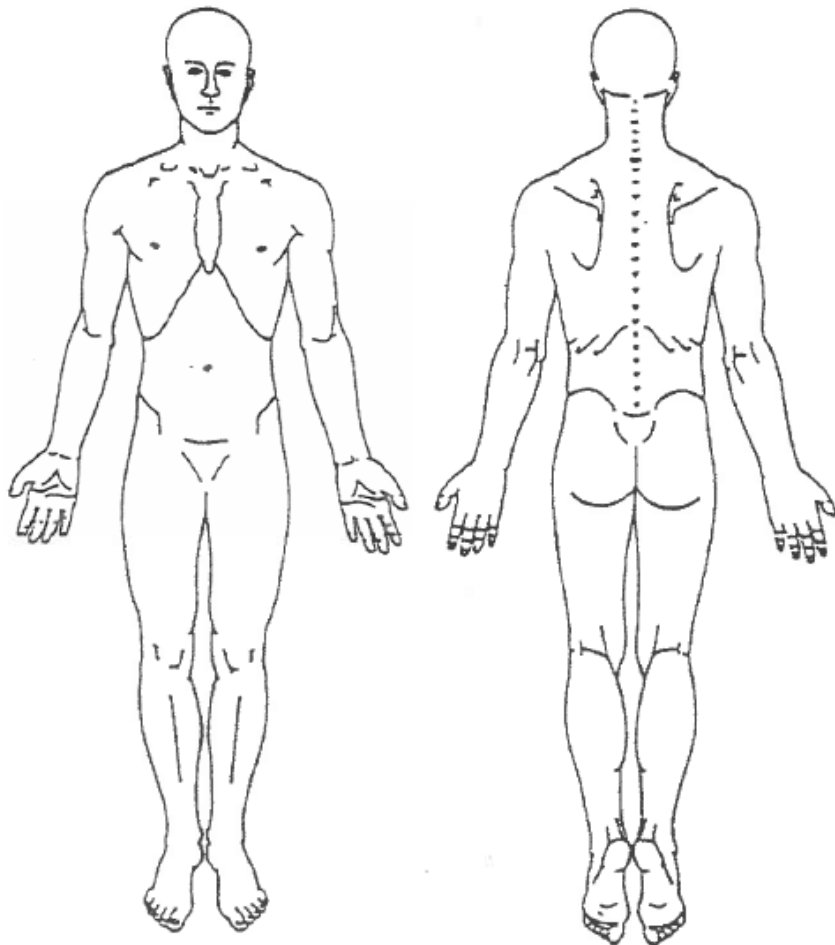
Doctor of Physical Therapy

LIVING WELL THERAPY, LLC

Instructions

Indicate where your pain is located on the chart below and what type of pain you feel at the present time. Please circle the "type" of pain you are experiencing. Please include areas of pain which are not related to your present injury or condition. On a scale of 1 to 10 with 10 being the worst, please indicate the number of pain next to the body part that you have marked.

THROBBING	DULL	ACHY
SHOOTING	SHARP	PINS/NEEDLES
BURNING	TINGLING	NUMBNESS
STABBING	CUTTING	OTHER (Please Describe)



CANCELLATION AND NO SHOW POLICY:

At Living Well Therapy, we pride ourselves on making our patients our number one priority. We provide one-on-one treatment with hands-on, compassionate care and put a priority on scheduling each patient for the necessary time needed for treatment. We schedule patients effectively, and keeping this in mind, we try to minimize any delays. When patients are scheduled for a physical therapy session, that time is set aside for that person and that treatment. Patients who fail to show for their scheduled appointments or fail give 24 hours previous notice prevent us from scheduling another patient in that slot who may need our services. We do understand that sometimes unforeseen circumstances arise that are beyond patients control.

We are initiating a policy that allows us to charge patients a \$50.00 fee if they fail to call and cancel their appointment 24 hours in advance. The charge is outside of any managed care contract and is the sole responsibility of the patient. Patients must pay this before their next scheduled appointment. If a patient has a history of three times with either a “no-show” or “no-call” this may result in termination of care.

We ask for your cooperation in this matter.

Signature of patient: _____ Date: _____

NON-CONTRACTED INSURANCE AUTHORIZATION FOR TREATMENT:

In presenting my insurance card on today's date _____, I have been made aware that *Living Well Therapy* is not contracted with my insurance plan. Therefore, I am choosing services that are considered “out-of-network”. It has been explained to me that since I have elected to do this I may have a higher cost share, deductible or co-payment, or my insurance may not pay at all.

I will contact my insurance and gather the necessary information so that I may be better informed as to what my insurance may or may not pay towards my physical therapy costs. I agree to pay all costs incurred by me, which may not be paid by my insurance.

Signed: _____ Date: _____

Office Manager: _____ Date: _____



Patients Name: _____ Date: _____

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that your insurance will not pay for the item(s) or service(s) that are described below. Insurance does not pay for all your health care costs. Your insurance only pays for covered items and services when the rules are met. The fact that your insurance does not pay for the item or service **does not** mean that you should not receive it. There is a good reason why your doctor is recommending it. Right now in your case, we believe that your insurance will not pay for:

Items or Services:

- 1) LASER Therapy \$ 29.00
- 2) ELECTRICAL STEM \$36.00 *Hot/Cold Pack is a no charge service
- 3) SUPPLIES – Cost varies

Because: MEDICAL NECESSITY

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you have to pay for them yourself and then get reimbursed from your insurance. Before you make a decision, about your options, you should read this entire notice carefully.

_____ Option 1: YES. I want to receive these items or services. I understand that I must pay for the items at the time of service and can receive a receipt for the cost of the item or service for insurance purposes.

_____ Option 2: NO. I have decided not to receive these items or services.

Date: _____ Signature of patient: _____

Living Well Therapy, LLC
541-312-2004
541-312-2056 (fax)

Release of Information Authorization

This authorization must be written, dated and signed by the patient or by a person authorized by law to give this authorization.

I, _____
print full name *date of birth*

Authorize Living Well Therapy, to request or release a copy of my healthcare record from or to:

Name of facility, or person to whom this information is to be released

Address

Street *City* *State* *Zip Code*

The information will be used on my behalf for the following specified purpose:

By initialing the spaces below, I specifically authorize release of the following records:

_____ The entire medical record (all information). The above named recipient understands this record may be voluminous and agrees to pay all reasonable charges associated with providing this record.

- | | |
|---------------------------------------------------------------------------------------|-------------------------------|
| _____ Medical Records needed for continuity of care | _____ Laboratory reports |
| _____ Most recent five year history | _____ Pathology reports |
| _____ Office Chart notes only | _____ Diagnostic imaging |
| _____ Hospital reports or records | _____ Physical therapy record |
| _____ Billing statements | _____ Other _____ |
| _____ HIV/AIDS information (Must be initialed to be included in other documents) | |
| _____ Mental health information (Must be initialed to be included in other documents) | |
| _____ Drug/alcohol information (Must be initialed to be included in other documents) | |
| _____ Genetic information (Must be initialed to be included in other documents) | |

This authorization is limited to the following treatment and time periods:

Please specify with dates of service, body part and type of injury

Signed _____
Patient, or person authorized by law *relationship to patient*

Date _____
This authorization is valid for 180 days from this date and may be revoked at any time but not retroactive to a disclosure of information made in good faith.