



610 Deer Cross Court East • Madisonville, LA 70447 • Phone # 985-898-0721 • Fax # 985-898-0725

WELCOME

We are glad that you have chosen The Next Level PRC for your rehabilitation needs. We are committed to providing you with the best possible care and in order to insure that your time with us will be a satisfactory experience, the following information concerning the management of this practice is offered.

APPOINTMENTS

Services are provided by appointment only. Please make your return appointment when you leave. If you are unable to keep your appointment or run late, we ask that you please notify us as soon as possible so that the appointment will be available for someone else. We may assess a fee for repeated missed appointments which are not cancelled in a timely manner. Appointments are available Monday thru Friday, 8:00 a.m. – 5:00 p.m.

FINANCIAL POLICY

If you have health insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy. We must emphasize that a Physical Therapy provider, our relationship is with the patient, not the insurance company. While filing insurance is a courtesy we extend to all of our patients, all charges are your responsibility. You will have the opportunity to sign out and view your charges at the end of each session. It is your responsibility to check these charges. Before your initial visit, we will contact your insurance company for verification of coverage and benefits. **IMPORTANT** – To ensure full benefits, verify with you insurance booklet the benefits you have regarding physical therapy. Each policy may have different guidelines. Some insurance companies require a referral number or pre-certification prior to the start of treatment.

Insurance is filed weekly and you will receive a statement monthly. We require that any portion of charges not covered by insurance is paid at the time of service or on a weekly basis. If this places a hardship on you for any reason or if you have questions regarding this policy, PLEASE feel free to ask the business office and we will be happy to assist you in any way possible. For accounts other than those covered by health insurance other arrangements will be made on an individual basis.

Should you have any questions or uncertainty concerning this matter, PLEASE do not hesitate to ask. We are here to help you.

Patient Signature (parent if minor)

Date



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Hours of Operation

Monday thru Friday 8:00 a.m. – 5:00 p.m.

Returned Checks:

There will be a \$15.00 fee, charged to the patient, for checks returned due to insufficient funds.

Verification of Your Insurance & Your Benefits:

Health insurance coverage is verified the day of your first visit, unless your first visit is after hours, which in turn, we will verify your benefits the following business day.

HOWEVER, it is YOUR RESPONSIBILITY to provide all up-to-date information for us to determine your insurance coverage.

It is your, the patient's, responsibility to know your insurance benefits and coverage. Be sure to know these benefits because you, the PATIENT, is ultimately responsible for what the insurance does not cover.

In addition, according to Health Insurance Companies, our verification IS NOT A GUARANTEE OF PAYMENT. Please call your insurance if you have any questions or concerns.

IT IS THE PATIENT'S RESONSIBILITY TO INFORM US IF YOUR BENEFITS CHANGE OR IF YOU ARE GOING TO THERAPY ELSEWHERE. IF YOU DO NOT, YOU WILL BE LIABLE FOR ALL CHARGES THAT ARE DENIED.

MEDICARE PATIENTS:

Medicare Deductible:

The United States Government instated a \$124.00 deductible for Medicare patients for the year 2006. We will not make the patients pay out their deductible during their visits because there may be pending transactions that will cover the deductible. If there are no pending transactions that you have paid on and covered your deductible, our billing agency will send you a bill for the amount of the deductible that you are liable for.

Medicare Cap:

Starting January 1st, 2006, there is a Medicare Patient Cap that was put on by the United States Government in regards to physical therapy for Medicare Patients. This cap is \$1740.00, which equates out to approximately 14 visits allowed per year. Once you have used the entire cap, Medicare insurance will not cover your treatment at our facility. A request system for more funds is being considered by the government, but has not been determined yet. As it stands right now, you will be allowed to continue physical therapy at our facility for our Discounted Private Pay of \$50.00 per visit.

**THE NEXT LEVEL PRC, LLC
INTAKE FORM**

PATIENT INFORMATION: EMAIL ADDRESS: _____ **DATE:** _____
First Name: _____ Last Name: _____ Middle Initial: _____
Address: _____ City: _____ State: _____ Zip: _____
Birth date: _____ Age: _____ Male _____ Female _____ S.S.#: _____
Home Phone: _____ Alternative Phone (Cell, Work): _____ Spouse: _____
Chose Clinic Because/Referred to Clinic By: Dr. _____ Insurance _____ Family _____ Friend _____ Website _____
Former Patient _____ Close to Work/Home _____ Yellow Pages _____ Other _____

CARE PROVIDER INFORMATION:
Referring Dr.: _____ Regular Dr./PCP: _____

INSURANCE INFORMATION:
Ins. Name _____
Subscriber's Name (If not patient): _____ D.O.B.: _____
Patient's Relationship to Subscriber: _____
Secondary Ins. Name _____
Secondary Insurance Subscriber: _____ D.O.B.: _____
Patient's Relationship: _____

AUTO/WORK INJURY CLAIM:
Adjuster/Claim Manager: _____ Phone: _____
Claim #: _____ D.O.I.: _____

ATTORNEY INFORMATION:
Name: _____ Phone #: _____

IN CASE OF EMERGENCY:
Name: _____ Relationship: _____ Phone#: _____

I have **INSURANCE** and would like to . . .

- Have you deal directly with them. I will assign my benefits to you by signing the "Assignment of benefits" agreement below. Fees may apply. The following information is required prior to your first visit.

My coinsurance/copay each visit is \$ _____ We will collect an estimated _____ per visit.
My deductible is \$ _____. You have _____ remaining of your deductible.

I have an **ATTORNEY** and would like to . . .

- Get a 30% discount by paying up front. I'll get reimbursement after my case settles.
- Wait until my case settles before paying. I will complete an "Attorney Lien" form. By accepting this option, I forfeit any future discounts and agree to pay the bill in full within 30 days of the case settlement. Fees may apply.

I authorize my insurance benefits be paid directly to The Next Level PRC. I understand that I am financially responsible for any balance. I also authorize The Next Level PRC to release any information required to process my claims. By signing below, I authorize the release of any medical or other information necessary to obtain payment from my insurance company or any other third party that is liable for payment for services rendered. I hereby authorize and direct my insurance company or companies, attorney or any other entity financially covering my treatment at The Next Level PRC to make direct payment to The Next Level PRC under any and all applicable coverage, including major medical, for covered charges for services rendered. I also authorize the use of my medical information for managing my health care as well as any related services. In addition, I authorize the use of my medical information for the practice's health care operations for the purposes of management or administration of the practice and of offering quality health care services. By signing below I am confirming that I have been given a detailed summary of the NOTICE REGARDING PRIVACY OF PERSONAL HEALTH INFORMANTION.

PATIENT/GUARDIAN SIGNATURE _____ **DATE** _____

PAST MEDICAL HISTORY

PAST MEDICAL HISTORY FORM

Patient Name _____

BLOOD PRESSURE	YES	NO	JOINT CONDITIONS	YES	NO
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
Normal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremity Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE	YES	NO	OTHER CONDITIONS	YES	NO
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerotic Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
MUSCLE CONDITION	YES	NO	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Carpal Tunnel R/L	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Tennis Elbow R/L	<input type="checkbox"/>	<input type="checkbox"/>	Poor Eyesight	<input type="checkbox"/>	<input type="checkbox"/>
Back/Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Limited Limb Movement	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
			Other: _____		

LUNGS	YES	NO			
Asthma	<input type="checkbox"/>	<input type="checkbox"/>			
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>			
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>			

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Low	<input type="checkbox"/> Smoking Packs a Day _____
<input type="checkbox"/> 1-2 x Week	<input type="checkbox"/> Standing	<input type="checkbox"/> Medium	<input type="checkbox"/> Alcohol Drinks a Week _____
<input type="checkbox"/> 3-4 x Week	<input type="checkbox"/> Light Labor	<input type="checkbox"/> High	<input type="checkbox"/> Coffee/Soda Cups a Week _____
<input type="checkbox"/> 5+ x Week	<input type="checkbox"/> Heavy Labor		
What types of exercise do you perform? : _____			
What things cause stress in your life? : _____			

Are you taking any seizure medication? YES NO If yes list name: _____

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?

YES NO If yes list name: _____

List all medications you are currently taking: _____

List all surgeries in the past two years (Including dates): _____

Are you pregnant? YES NO What week?: _____

Have you had any injuries related to work? YES NO If yes list body part and date.: _____

Have you had any Auto Accidents YES NO If yes list body part and date.: _____

Have you had Physical Therapy or Massage Therapy before? YES NO Where: _____

PATIENT/ GUARDIAN SIGNATURE

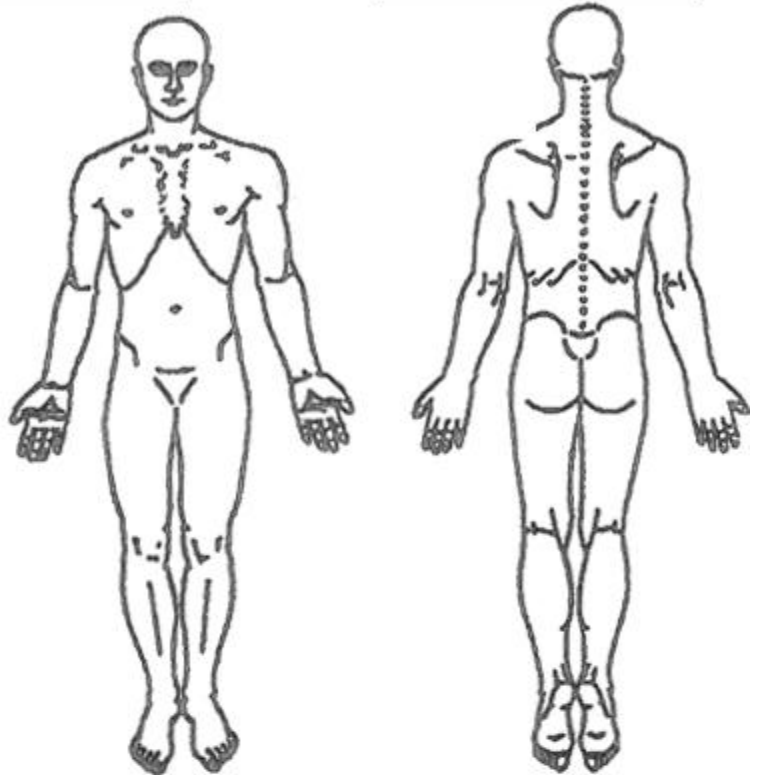
DATE

Pain and Symptom Status Report

Name: _____

Date: _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing



Ache
MMM
M

Burning

Numbness
OOOO
OOO

Pins and Needles
□□□□□□□□
□□□□□□□□

Stabbing
/////

Other
xxxx
xxx

Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____

Date First Symptom of your problem occurred on: _____

2nd Complaint: _____

3rd Complaint: _____

Please circle on the scale below to indicate your CURRENT level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Please circle on the scale below to indicate your AVERAGE level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Please circle on the scale below to indicate your WORST level of pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it gets.

Additional Comments _____



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Patient Responsibilities

We provide the best physical therapy in the region. We are only able to do this if our patients agree to and comply with the below patient responsibilities:

1) You agree to show up on time, dressed for the right environment (gym/turf) and at the right hour.

When you are late, show for the wrong environment or come at the wrong hour, we are forced to handle a patient load that we did not anticipate. This hurts not only your care, but other patients' care as well. First of all, you don't receive the direct care we anticipated giving you. Secondly, the other patients who are here when you show up do not get the direct care that they were scheduled for. Lastly, we stress trying to give everyone the same excellent service despite the difficult circumstances.

2) You agree to comply with your treatment plan as prescribed by your physical therapist, including:

- a. Showing up for all of your visits each week
- b. Showing up ready for the right environment.
- c. Performing your home exercises as prescribed to you.
- d. Performing &/or adjusting any other daily or nightly activities that you are asked to alter.

3.) Missed appointment policy: A missed appointment is when you fail to show up for an appointment without a phone call, or cancel without at least 24-hour notice.

- a. **1st Missed Appointment: We'll call and offer to reschedule your appointment. May be charged \$20 fee.**
- b. **2nd Missed Appointment: We'll call and offer to reschedule your appointment. May be charged \$25 fee.**
- c. **3rd Missed Appointment: You will be charged a \$25 fee. This may result in a discharge from clinic.**

We have had amazing success with our patients due to the fact that they comply with their treatment plan, show for their visits and come ready for the right environment. If you have any concerns, time or financial restrictions, please bring them to our attention, so that we can figure out how to handle the situation. We will work with you to help you integrate physical therapy into your life's schedule, so that we can resolve your issue.

The front office is only responsible for collecting moneys due to the clinic and scheduling the patients as instructed to do so by the caregivers on your checkout sheet. They cannot change treatment plans, including the number of visits per week that you attend, the number of weeks planned for your treatment or even the environments that you are to be treated in for each visit. All such questions must be directed to your caregivers. If you are forced to cancel one of your prescribed visits and you are not able to set a makeup for a different day of that week, it is your responsibility to relay this to your CAREGIVER as well as the front office.

By signing below, you are stating that all your questions have been answered, so that you completely understand what is expected of you during your treatment at our facility. By signing below you are also declaring that you understand that your physical therapist may conclude your treatment at our facility at any point in time if you do not comply with all the responsibilities enveloped within this agreement.

Patient Printed Name

Date

Signature



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PHOTO/TESTIMONIAL RELEASE FORM
PERMISSION TO USE IMAGE/TESTIMONIAL DATA

I, _____, give The Next Level Physical Therapy, it's employees, designees, legal representatives, and all persons or departments for whom or through whom it is acting, the absolute right and unrestricted permission to take, use my name, testimonial and biographical data and/or publish, reproduce, edit, exhibit, project, display and/or copyright photographic images, pictures or video of me or my child(ren), whether still, single, multiple, or moving, or in which I (they) may be included in whole or in part, in color or otherwise, through any form of media (print, digital, electronic, broadcast or otherwise) for art, advertising, marketing, fund raising, publicity, archival or any other lawful purpose.

I waive any right that I may have to inspect and approve the finished product that may be used or to which it may be applied now and/or in the future, whether that use is known to me or my child(ren) or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image or product. I release and agree to hold harmless The Next Level Physical Therapy, employees, and/or others for whom or by whom The Next Level Physical Therapy is acting, of and from any liability by virtue of taking of the pictures or using the testimonial/biographical data, in any processing tending towards the completion of the finished product, and/or any use whatsoever of such pictures or products, whether intentional or otherwise.

I certify that I am at least 18 years of age (or if under 18 years of age, that I am joined herein by my parent or legal guardian) and that this release is signed voluntarily, under no duress, and without expectation of compensation in any form now or in the future.

Name (Please print)

Date

Signature (Signature of parent or legal guardian if under 18 years of age)



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NOTICE OF PATIENT INFORMATION PRACTICES

The Next Level PRC 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

The Next Level PRC uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluation the quality of care that we provide. For example, The Next Level PRC 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.

The Next Level PRC may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, The Next Level PRC'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.

The Next Level PRC 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 when specifically authorized by you, when required by law or in emergency circumstances. The Next Level PRC will consider all such requests on a case by case basis, but the practice is not legally requires to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that The Next Level PRC 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 above. You may also send a written complaint to the US Department of Health and Human Services. For further information on The Next Level PRC's health information practices or if you have a complaint, please contact the following person: James Silvestri, P.T.