Flagstaff Integrated Therapies

WELCOMES YOU

What FIT Means to Us

Flagstaff Integrative Therapies is an integrative physical therapy center that helps people flourish and thrive, with the focus being movement.

Humans tend to rely on unconscious movement patterns that can create tension, aches, and pains.

At FIT, we liberate our clients by unlocking and replacing these patterns. And then, we integrate the new patterns into their favorite activities. Making sure our clients are heard leads to long-term success because they are doing what they love, just a little differently.

Welcome Information: Things to Know

WiFi

FIT-Guest

Password: FITclient

Virtu

Virtu is an email encryption and data security application used for business privacy. At FIT we value and honor your personal information. Any and all files and emails we send are secured and encrypted through Virtu if they contain protected health information (PHI.) If you would like to learn more about this application and the various features Virtu offers, you can visit their website at https://www.virtru.com/.

Next Steps

Please read through and fill out the following new client documents prior to your first visit OR arrive 15 minutes prior to your appointment time to fill them out in the office.

We are very happy to have you here and hope that your time with us fulfills your needs. Thank you for choosing Flagstaff Integrated Therapies!

Client Name:

Outpatient Therapy for Medicare Beneficiaries

Reference: Medicare Benefit Policy Manual: 220.2 - Reasonable and Necessary Outpatient Rehabilitation Therapy Services (Rev. 179, Issued: 01-14-14. Effective: 01-07-14, Implementation: 01-07-14)

To be covered, services must be reasonable and necessary skilled therapy services. Skilled therapy services may be necessary to *improve* a client's current condition, to *maintain* the client's current condition, or to *prevent or slow further deterioration* of the client's condition. General exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, do not constitute therapy services for Medicare purposes.

Medicare defines *skilled services* as services at such a level of complexity and sophistication or the condition of the patient shall be such that the services required can be safely and effectively performed *only* by a therapist or under the supervision of a therapist (PTA). If a service can be self-administered or *safely and effectively* furnished by an unskilled person (like a hired caregiver or family member), the service cannot be regarded as a skilled therapy, *even if they are performed by a qualified professional* such as a PT. The bottom line is, "coverage does not turn on the presence or absence of a beneficiary's potential for improvement from the therapy, but rather on the beneficiary's *need for skilled care*." There are two types of skilled therapy, rehabilitative and skilled maintenance.

Rehabilitative therapy includes treatment designed to address *recovery* or *improvement* in function and, when possible, restoration to a previous level of health and well-being. Rehabilitative therapy requires the skills of a therapist to safely and effectively furnish a recognized therapy service whose goal is *improvement* of an impairment or functional limitation. It is *important to understand* that if an individual's expected rehabilitation potential is insignificant in relation to the amount of therapy services required to achieve such potential, rehabilitative therapy is *not* reasonable and necessary and therefore *not* a covered benefit under Medicare Part B.

Skilled maintenance has the goal to *maintain* functional status or to *prevent or slow further deterioration* in function. Skilled maintenance coverage can be used to establish or design a maintenance program and *if needed*, perform periodic reassessments. Generally, the execution of a maintenance program can be carried out by the beneficiary and/or a trained caregiver. Once this training is completed, Medicare payment is no longer appropriate. If the services are skilled (see above), it is a covered Medicare benefit and Medicare should be used. As with both types of therapy services, the *deciding factors* are always whether the services are considered reasonable, effective treatments for the patient's condition and *require the skills of a therapist*, or whether they can be safely and effectively carried out by nonskilled personnel or caregivers.

Signature: _____ Date: _____

Client Information

Name: _____ Date of Birth: _____
Address: _____ City: _____ State: ___ Zip: _____
Best Phone: _____ E-mail: _____ SSN: _____
Responsible Party: _____ Phone: _____ Relationship: _____

Reason for visit:_____ First date of symptoms: _____

Employer: _____Occupation: _____
Referring Person: _____ Phone: _____
Primary Care Practitioner: _____Phone: _____

Was your injury a result of an accident? Yes/No If yes, was it job related?_____
Auto: _____Other: _____

Payment Information:

Cash Payment: _____ (initial here)
Prices: Initial Visit for Comprehensive Evaluation: $120 90 min; Follow up visits: $85 per hour

Primary Insurance Company: _____ Phone Number: _____
Policy #: _____ Group #: _____
Effective Date: _____Secondary Insurance? _____
Policy Holder: _____Birth Date: _____ Best Phone: _____
Relationship to Patient: _____ Policy Holder's SSN: _____

Additional Comments:

_____
_____
_____
_____
_____

_____ _____ _____
Client Printed Name Client Signature Date

Accepted by: _____

Please READ CAREFULLY and INITIAL in the space provided indicating you have been given a chance to ask questions and now fully understand all of the following policies.

____ **PAYMENT** is requested at the time of service. We accept cash, local check, credit/debit cards, FSA, and HSA cards.

____ **INSURANCE:** If using insurance, please be aware that each insurance contract has different deductible, co-pay, and/or co-insurance amounts. We will do our best to help you understand your particular insurance policy. **Your insurance contract is between you and your insurance company.** We will bill your insurance company as a courtesy. **However, if your insurance denies ANY PORTION of an authorized claim or if benefit payment differs from the amount/percentage previously quoted to us by your insurance, you are responsible for all charges.**

____ Insurance coverage is different for every person, **even within the same insurance company**. The specific requirements for covered physical therapy benefits are *specific to your policy*. You are **ULTIMATELY RESPONSIBLE** for understanding your policy and any and all charges not covered by your insurance policy. We strongly recommend you personally check your policy for details of your coverage by calling the phone number on your card. This will help you make *informed decisions* on using your healthcare dollars.

____ We are currently accepting most **BCBS** plans and **Traditional/Railroad Medicare Part B**. If your insurance requires pre-authorization, please be sure this has been done PRIOR to scheduling your first appointment. If a client attends an appointment prior to verification/ authorization, and the visit is denied by the insurance company, the cost of that visit will be the **client's responsibility** (1st visit is typically $130 and then $95 per hour for follow up visits).

____ You will receive monthly statements until your account is paid in full. If your insurance has not paid within 90 days, we will **expect payment in full from you**, as you are ultimately responsible. If, after that time, your insurance does make a payment, we will issue a refund check.

____ **CANCELLATION POLICY:** I agree to give a **minimum 24 hr** cancellation notice for all non- medical OR weather related reasons. If I fail to do so, I agree to pay the **cost of my usual session** (typically $95) I realize my insurance company is *not responsible* for these charges.

____ **APPOINTMENTS:** Clients are seen by appointment only. To make it easier on you, we use on-line booking available at www.fit-llc.com/book-online. We recommend scheduling at 1-2 week intervals as time slots tend to fill up.

____ **COLLECTOR'S FEE:** A fee will be added to all account balances sent to collections. I understand payment options are available as arranged with Flagstaff Integrated Therapies management.

_____	_____	_____
Client Printed Name	Client Signature	Date

Accepted by: _____

Request for Medicare Payment of Services

(CMS-1500, Items 12 & 13)

A participating provider must use a procedure to demonstrate the signature of the client (or representative) is in his/her records that will serve as a *request for payment for services* from the provider.

Name of Beneficiary _____ **HICN** _____
(client name) (medicare number)

I request payment of authorized Medicare Physical Therapy benefits on my behalf for any services furnished to me by Flagstaff Integrated Therapies. I authorize Flagstaff Integrated Therapies to release to Medicare and its agents any information needed to determine these benefits or benefits related services. I understand that this is a one time authorization and will remain in full effect until I request to revoke it.

Signature _____ Date _____
(client or authorized agent)

Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services (Rev. 241, 02-02-18) Section 50.1.2 - Beneficiary Request for Payment on Provider Record - ASC X12 837 Institutional Claims (Rev. 3086, Issued: 10-03-14, Effective: ICD-10: Upon Implementation of ICD-10, ASC X12: January 1, 2012, Implementation ICD-10: Upon Implementation of ICD10; ASC X12: November 4, 2014)

IMPORTANT - Please Read:
Physical therapy is a mandatory benefit under the Medicare program. The only situation in which physical therapists are not required to submit claims to Medicare for covered services is when a beneficiary or the beneficiary's legal representative, of his/her *own free will*, refuses to authorize the submission of a bill to Medicare. If you refuses to sign this form, Flagstaff Integrated Therapies will NOT bill Medicare on your behalf. You will be liable for the full charges. However, Flagstaff Integrated Therapies may *not* charge more than the Medicare allowed amount for the covered service, notwithstanding the absence of a claim to Medicare.

Medicare Benefit Policy Manual Chapter 15 – Covered Medical and Other Health Services (Rev. 241, 02-02-18) Section 40 - Effect of Beneficiary Agreements Not to Use Medicare Coverage (Rev. 160, Issued: 10-26-12, Effective: 01-28-13, Implementation: 01-28-13)

Acknowledgement of Receipt of Privacy Notice Page 1 of 2

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by Flagstaff Integrated Therapies LLC (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice or understand it is located on the website at https://www.fit-llc.com/fees-ins bottom of the page

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: *1515 N Main Street Suite B, Flagstaff, AZ, 86004*, Attention: Compliance Officer

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions):

_____

Acknowledge of Receipt of Privacy Notice Page 2 of 2

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

By signing this form, I acknowledge that I have reviewed an executed copy of this acknowledgement and a copy of the Practice's Policy Notice and agree to the Practice's use and disclosure of my protected health information for treatment, payment and health care operations.

_____ _____

Signature of Client or Representative Date

Client's Name:_____

Date of Birth:_____

Social Security Number:_____

_____ _____

Name of Personal Representative (if applicable) Relationship to Client

To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set above are:

Accepted Denied Not Applicable

Other (explain)_____

_____ _____

Signature of Authorized Practice Representative Date

Client Name:

Consent to Treat

This Release, Waiver and Assumption of Risk ("Agreement") is entered into by and between Flagstaff Integrated Therapies LLC, its agents, owners, officers, volunteers, employees, and all other persons or entities acting in any capacity on their behalf (hereinafter collectively referred to as FIT) and _____ (client), on behalf of himself/herself and his/her, heirs, assigns, spouse, personal representative and children (hereinafter collectively referred to as "Participant").

FIT provides House Call outpatient physical therapy and physical therapy sessions located in our office located at **1515 N Main Street Suite B, Flagstaff, AZ, 86004**. Recommendations and treatments are given including, but not limited to: Evaluations and Re-evaluations, Therapeutic exercise, Therapeutic Activities, Neuromuscular Re-education, Gait Training, and Manual Therapy Techniques including soft tissue mobilization, traction, joint mobilization/manipulation, and dry needling. Participation in such sessions, or any instruction, or any related services is collectively referred to as "therapy". The parties agree as follows:

1. Participant acknowledges that Therapy entails known and unknown risks which simply cannot be eliminated. Such risks include without limitation, physical and/or emotional injury; after session soreness; exacerbation of condition; infections; bruising; bleeding; injury to internal organs including but not limited to lungs, kidneys, nerves and blood vessels; paralysis, illness; or damage to Participant; third parties or property; slips and falls; equipment failure, hypothermia, burns, abrasions; musculoskeletal injuries; head injuries; dehydration; dismemberment; and/or damage to property (collectively "Risks")
2. Participant agrees to all interventions, treatments, and all necessary and appropriate care for his/her condition; acknowledges and agrees that participation in Therapy is purely voluntary and without reliance upon any statement or representation by FIT and elects to participate in spite of the Risks; and expressly assumes and accepts such Risks.
3. Participant certifies that he/she is in sufficiently good health for Therapy; has consulted with or has had the opportunity to have consulted with a physician concerning participation in such Therapy; agrees to personally satisfy himself/herself as to the safety of all FIT equipment and facilities, and their acceptability for Therapy and will cease such Therapy and notify FIT immediately if Participant becomes aware of any unsafe condition.
4. Participant acknowledges that touching through clothes or, if necessary, skin to skin contact, may be necessary as part of the Therapy and consents to the same. Participant will be appropriately draped exposing only necessary areas for treatment. If a minor, a guardian will be present unless written permission is given to FIT.
5. If a court of competent jurisdiction makes a final determination that any term or provision of this Agreement is invalid or unenforceable, all other terms and provisions shall remain in full force and effect. In the event an arbitration, suit or action is brought by any party under this agreement to enforce any of its terms, or in any appeal therefrom, it is agreed that the prevailing party shall be entitled to reasonable attorneys' fees and costs. This Agreement shall be binding upon the parties, their successors, assigns, heirs and/or personal representatives.
6. Participant agrees that FIT shall not be responsible or liable for any lost, stolen or damaged items, nor for any damages while in participants home nor loss to Participant's automobile or contents thereof while parked in either the front or parking lot at 1515 N Main St Suite B, Flagstaff, AZ, 86004 nor the nearby streets of Main Street nor Johnson Street.

My signature below indicates that I have read and understand this Agreement; have entered into it voluntarily and intelligently; and agree to be bound by its terms; and if the parent of a Minor, sign on behalf of myself and my child.

_____	_____	_____
Client's Printed Name	Client's Signature	Date

Client Name:

Health History

Name:_____ **Age:**_____
Height:_____ **Weight:**_____

Occupation/Hobbies:
_____
_____

How did your symptoms start? (check all that apply)
( ) Suddenly ( ) Pulling
( ) Gradual ( ) Pushing
( ) Lifting ( ) Bending: right/left
( ) Unable to determine ( ) Injured at work
( ) Other:_____

What activities make symptoms worse?
( ) During exercise ( ) Bending forward
( ) After exercise ( ) Bending backward
( ) Sitting ( ) Standing
( ) Walking ( ) Twisting: right/left
( ) Coughing/Sneezing ( ) Breathing
( ) Other:_____

What reduces your symptoms?
( ) Lying down ( ) Pain pills
( ) Sitting ( ) Injections
( ) Standing ( ) Muscle relaxants
( ) Walking ( ) Anti-inflammatories
( ) Heat/Ice (circle) ( ) Anti-anxiety pills
( ) Meditation ( ) Massage
( ) Acupressure/puncture ( ) Nothing
( ) Other:_____

How long have you had these symptoms?
___Years ___Months ___Weeks ___Days

Have you had any of the following?
( ) X-ray Date:
( ) CT Scan Date:
( ) Myelogram Date:
( ) EMG Date:
( ) Discogram Date:
( ) MRI Date:
( ) ARthrogram Date:
( ) Injection Date:
( ) Other:_____ Date:

Hospitalization for this problem?_____
Surgery for this problem:_____
Date: _____

Have you ever had any of the following?

	Comments
Allergies (latex, meds,etc.)	Y / N
Diabetes (circle 1 or 2)	Y / N
High Blood Pressure	Y / N
Heart disease, murmurs	Y / N
Stroke/head Injury	Y / N
Recent antibiotics	Y / N
Cancer or tumors	Y / N
Lung problems/ asthma	Y / N
Coumadin/ blood thinner use	Y / N
Joint Difficulties/ replacements	Y / N
Dizziness/ disequilibrium	Y / N
Nervous disorders/ anxiety	Y / N
Visual problems/ Corrective lens	Y / N
Immunity disorders	Y / N
Possibly pregnant	Y / N
Recent medication use	Y / N
Sleeping difficulties	Y / N
Increased thirst/hunger	Y / N
Frequent Urination	Y / N
Indigestion or heartburn	Y / N
Nausea or vomiting	Y / N
Changes in memory	Y / N
Unusual fatigue/weakness	Y / N
Fever or chills	Y / N
Easy bruising/bleeding	Y / N
Bowel issues (IBS, gas)	Y / N
Frequent muscle cramping	Y / N
Pain 24 hrs	Y / N
Pain wakes you up	Y / N
Missing teeth, crowns, grinding	Y / N

What other doctors, chiropractors, massage therapists, yoga therapists, or other healthcare practitioners do you see?
_____
_____

Have you felt down or depressed in the last month?_____
_____

How did you hear about our services?
_____

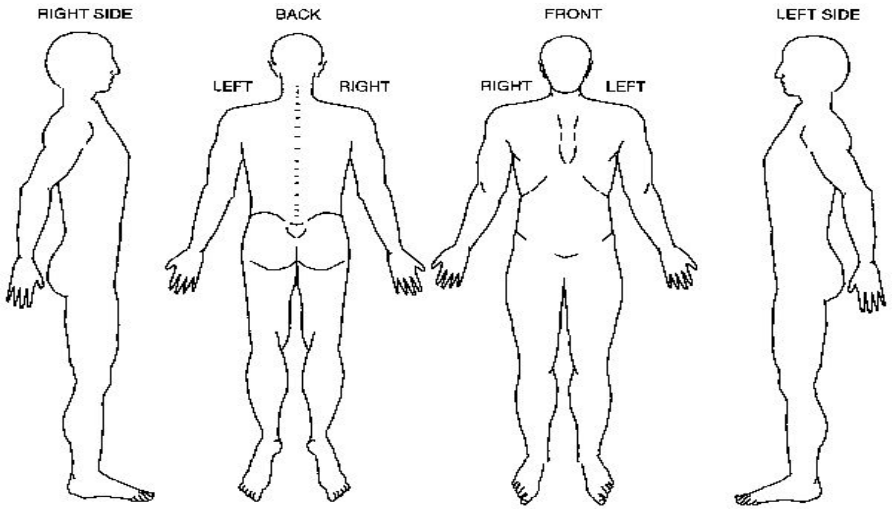
Any other information you choose to provide? _____
_____

Client Name:

Pain Diagram

Instructions: Please mark the area of your current symptoms or discomfort using the chart below.

Numbness	Pins & Needles	Burning	Aching	Stabbing	Other _____
----------	oooooooooo	///////////////	xxxxxxxx	^^^^^^^^^	*********



Instructions: Please record your level of pain on the three lines below. Please use the symbol indicated.

0 10

Level of Pain right now [X]

0 10

Level of Pain in last 24 hrs**:** Best [X] and Worst [O]

0 10

Level of Pain in the past week: Best (X) and Worst (O)

Name:_____ Date:_____

Patient Specific Functional Scale

We are interested in identifying up to three important activities that you are unable to do or are having difficulty with as a result of your _____ problem. Today, are there any activities that you are unable to do or are having difficulty performing because of your _____ problem?

Please write them down in the space provided.

Scoring Scale:

0 1 2 3 4 5 6 7 8 9 10

Unable to perform Activity — **Fully able to perform activity**

Activities	Score
1	
2	
3	

Name: _____
Date: _____