Sterling Physical Therapy & Wellness

209 Evans Drive
Mt. Sterling, KY 40353
859-498-0011
Fax: 859-498-5001

29 S. Court Street
Owingsville, KY 40360
606-336-3400
Fax: 859-498-5001

Date: _____
Patient Name: _____ Age: _____ Birthdate: _____
Address: _____ City: _____ State: _____ Zip: _____
SS#: _____ Home Phone: _____ Cell Phone: _____
Email Address: _____
Sex: Male ( ) Female ( ) Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed
Emergency Contact #1: _____ Phone: _____
Emergency Contact #2: _____ Phone: _____

Employment:( ) Full Time ( ) Part-time ( ) Unemployed ( ) Disabled ( ) Retired
Employer: _____ Address: _____
Phone #: _____ Date Last Worked: _____

Have you ever been treated in this clinic before? ( ) Yes ( ) No
Are you currently receiving Home Health Therapy? ( ) Yes ( ) No

Is your condition: ( ) Work Related
Claim #: _____ Adjuster/Rehab Nurse: _____
Employer (if different at time of injury): _____
Employer's Phone # or Case Manager Phone #: _____

Is your condition: ( ) Auto Related
Claim# _____ Adjuster: _____ Adjuster Phone Number: _____

Is your condition: ( ) Post-Surgical
Surgeon: _____ Date of Surgery: _____

Have you retained an Attorney? ( ) Yes ( ) No
Attorney's Name: _____ Phone Number: _____

Primary Care Physician: _____
Referring Physician: _____ Date return to MD: _____
How were you referred to our clinic? ( ) Physician ( ) Previous Patient ( ) Advertisement
( ) Friend ( ) Other: _____

Sterling Physical Therapy & Wellness

209 Evans Drive
Mt. Sterling, KY 40353
859-498-0011
Fax: 859-498-5001

29 S. Court Street
Owingsville, KY 40360
606-336-3400
Fax: 859-498-5001

GENERAL CONSENT
MEDICAL/FINANCIAL AUTHORIZATION AND RELEASE

Patient Name: _____
(Print Only)

I, the undersigned, a patient of **Sterling Physical Therapy & Wellness, PSC,** do hereby freely and voluntarily agree and consent to and authorize the administration and performance of all procedures and treatments, as prescribed by my attending physician, in accordance with the plan of treatment as set by my primary therapist.

I understand that no assurance or guarantees have been given by anyone concerning treatment or the results that may be obtained.

I understand that it is my responsibility to inform this office if the subscriber's insurance requires pre-certification for outpatient therapy services. Furthermore, I understand that I am financially responsible for all charges until my bill is paid in full. I hereby guarantee payment of all charges incurred for the account of the above-named patient. I understand that even after paying my co-payment at the time of service, I may still be responsible for charges of modalities/treatments not covered by my insurance benefits/company. I understand that it is impractical for **Sterling Physical Therapy & Wellness, PSC,** to know each patient's individual insurance policy exclusions regarding physical or occupational therapy services/treatments. Some insurance companies may not cover all physical or occupational services/treatments even if they are prescribed by the physician. I hereby authorize and request that all insurance benefits be made directly to **Sterling Physical Therapy & Wellness, PSC** on by behalf for any and all services performed by **Sterling Physical Therapy & Wellness, PSC.**

I authorize the release of my plan of care, evaluation and progress notes, if required by my physician, attorney, employer, or insurance company for payment of services rendered. Information will not be released to any other party without prior written consent.

I hereby verify that I have carefully read the foregoing GENERAL CONSENT, MEDICAL/FINANCIAL AUTHORIZATION AND RELEASE provisions and fully understand them in every detail and hereunder have freely and voluntarily affixed my signature.

PATIENT SIGNATURE: _____ **DATE:** _____

WITNESS SIGNATURE: _____ **DATE:** _____

ACKNOWLEDGEMENT:

I hereby acknowledge that I have the right to a full copy of **Sterling Physical Therapy & Wellness'** Notice of Privacy Practices, which is displayed in the lobby in its entirety, and understand that I can ask questions regarding this act at any time.

_____ _____
Patient Signature and Date **Witness Signature and Date**

Sterling Physical Therapy & Wellness

Jamie Baxter, MSPT **Christen Pate, MSPT**

PAYMENT POLICY

Effective immediately, our office must collect the co-payment your insurance plan requires prior to treatment.

Our contract with your insurance company requires that we collect the co-payment at the time of your visit. They are not obligated to pay the claim until we have collected co-payment.

We have enrolled in numerous insurance programs to accommodate the needs and requests of our patients; however, within the same insurance company plans differ depending upon what type of contract you and your employer has negotiated. Each plan has different policies regarding how often services may be rendered, differing co-payment amounts, and deductible amounts that may be applied to in office procedures. Payments for services not covered by the insurance company are **YOUR** responsibility.

In addition, all unpaid/outstanding balances will be charged an Annual Finance Charge of 18%. This is 1.5% monthly.

I have read the above payment policy and understand that I am personally responsible for any bill, or portion thereof, not paid by my insurance company and agree to terms and accept responsibility as described.

Signature **Date**

CANCELLATION AND NO SHOW POLICY

All missed appointments **MUST** be made up the same week so that you fully recover.

Sterling Physical Therapy & Associates requires 24-hour advanced notice for any cancellation. If you are unable to give a 24-hour advanced notice or you do not show for your appointment an Administrative Fee of $25.00 will be billed to you.

If you no show a total of 3 visits you will automatically be discharged and will require a new physicians order to return.

Signature **Date**

Sterling Physical Therapy & Wellness

Jamie Baxter, MSPT **Christen Pate, MSPT**

Here at Sterling Physical Therapy & Wellness we offer individualized treatment plans. Different types of treatment may include but are not limited to:

- Kinesio Tape
- Cupping
- Iontophoresis
- Hot and Cold Therapy
- Electrical Stimulation
- Therapeutic Exercise Programs

Though unlikely, there are risks associated with these types of treatment. Risks may include; bruising, redness, skin irritations, increased tenderness and/or swelling. Please notify one of our Therapists if you are currently taking a blood thinner, have a pacemaker, have a history of cancer or are sensitive to certain adhesives. If you have any questions or further concerns regarding treatment or risks please discuss this with your Physical Therapist.

Patient Name (Printed): _____

Patient Signature: _____ Date: _____

___ I was offered a copy of this consent and refused.