Medical History

Name: _____

Height: _____ Weight: _____

Existing or Relevant Previous Conditions (Circle Yes or No)

Alzheimer's	Yes/No	Muscular Dystrophy	Yes/No	Muscular Disease	Yes/No
Cardiovascular Disease	Yes/No	Obesity	Yes/No	Osteoporosis	Yes/No
Cauda Equina Syndrome	Yes/No	Osteoarthritis	Yes/No	Seizures	Yes/No
Cerebral Vascular Accident	Yes/No	Parkinson's	Yes/No	Strokes	Yes/No
Current Infection	Yes/No	Rheumatoid Arthritis	Yes/No	Tuberculosis	Yes/No
Diabetes Mellitus Type 1	Yes/No	Traumatic Brain Injury	Yes/No	Allergies/Asthma	Yes/No
Diabetes Mellitus Type 2	Yes/No	Lupus	Yes/No	Pacemaker	Yes/No
Fibromyalgia	Yes/No	Smoker	Yes/No	Metal Implants	Yes/No
Fracture/ Suspected Fracture	Yes/No			HIV/AIDS	Yes/No
High Blood Pressure	Yes/No			Currently Pregnant	Yes/No
History of Cancer	Yes/No			Anxiety	Yes/No
Huntington's	Yes/No			Headaches	Yes/No
Immunosuppression	Yes/No			Are you or have you been treated for depression?	Yes/No

Surgical History

Body Region: _____ Surgery Type: _____ Date: _____

Body Region: _____ Surgery Type: _____ Date: _____

Body Region: _____ Surgery Type: _____ Date: _____

Current Medications

Drug: _____Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

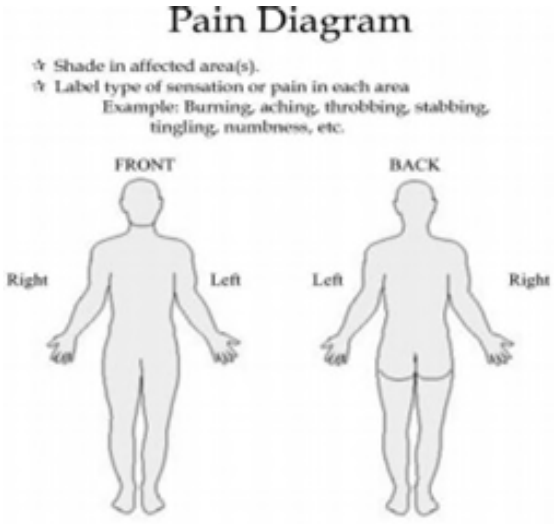
Drug: _____Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Additional Information:

_____
_____
_____
_____
_____
_____
_____

Injury as result of a fall in the past year? _____

Two or more Falls In the last year? _____



Draw a line on the pain intensity scale at the point that best describes your pain at the PRESENT time:

_____

0(No Pain) 1 2 3(Mild) 4 5(Moderate) 6 7(Severe) 8 9(Excruciating) 10 (Pain as bad as it could be)

FERRELL-WHITED PHYSICAL THERAPY FINANCIAL POLICY – 2025

INSURANCE: To properly bill your insurance company, we require that you disclose ALL insurance information including primary and secondary insurance, as well as any change of insurance information. Ferrell-Whited will contact your insurance company prior to services as a courtesy to verify insurance coverage; however, it is not a guarantee of benefits. You are responsible for all charges regardless of your existing medical coverage. If you are not insured by a plan we participate in, you are responsible for out-of-network rates. Your medical claim will be forwarded to your secondary insurance (if any) after payment and/or explanation of benefits (EOB) is received from your primary insurance company.

***Payment for approved services depends on your plan's benefit limitations and eligibility at time of service. Call the Customer Service number on the back of your insurance ID card to learn about what your plan covers, your costs, and to verify your eligibility.**

NO-SHOW/CANCELLATION POLICY: We understand there are times when you must miss an appointment due to an emergency. However, your doctor has prescribed physical therapy for you, and this is an on-going process which requires regular attendance. If you are late for an appointment, you may have to reschedule or accept an abbreviated treatment for that day. If you cancel/no-show three appointments, FWPT has the right to discharge you from care***. You understand and agree that FWPT requires a 24-hour advance notice of cancellation.*** **IF YOU FAIL TO GIVE 24-HOUR NOTICE OF CANCELLATION OR NO-SHOW AN APPOINTMENT, YOU WILL BE RESPONSIBLE FOR A *$50.00* CHARGE (WHICH IS NOT COVERED BY INSURANCE).**

DELINQUENT ACCOUNTS/COLLECTIONS: Outstanding patient responsibilities must be paid by you within 30 days after the date of the invoice sent to you. Failure to pay your invoice within 30 days will result in interest charged on your account in the amount of 2.0% per month. Account balances over 90 days will be sent to collections after no response from the patient. Statements will be mailed once per month for three months before becoming delinquent. **It is the patient's responsibility to inform the staff of any changes in address or insurance information. If not notified of insurance changes on or before new effective date, any claim denials will be the responsibility of the patient.**

COPAYMENTS AND DEDUCTIBLES: All co-pays must be paid at the time of service.

MEDICARE: We are a participating Medicare provider. **Per Medicare guidelines patients who are receiving in-home health care are not eligible for outpatient physical therapy services at the same time.** It is your responsibility to inform FWPT immediately if in-home health care services will be utilized at any time during treatment at FWPT.

WORKERS COMPENSATION: This office is a certified Ohio Bureau of Worker's Compensation provider and accepts approved claims. Any Disallowed Claim fees will be the patient's responsibility.

NON-COVERED SERVICES: Please be aware that some of the services you receive may not be covered by Medicare or other insurers. We will provide you with an advance beneficiary notice (ABN) for any services that Medicare or other insurers will not cover prior to providing the service to you. Such non-covered services will require your prior approval before they are provided. **You are responsible for payment of these services at the time the service is provided.**

BILLING: We bill all claims and send statements out of the main clinic. Please call **330-722-3781** for any questions concerning your statement balances and payments made on your account. Please let the billing department know if you have any difficulties resolving your bill. If your insurance company should happen to send payment to you, the patient, we expect that you would forward it to our office to be applied to your balance.

NON-SUFFICIENT CHECKS RETURNED: For patient payments that are returned due to non-sufficient funds a $35.00 charge will be added to your bill.

PATIENT SIGNATURE: _____ **DATE:**_____

FWPT requires patients that wish to make partial payments on a delinquent account to enter into a monthly payment agreement. The agreement requires the patient to make minimum payments to prevent the account from being sent to collections. **The monthly payment must be at or equal to twenty-five percent (25%) of the total outstanding delinquent balance to fulfill the agreement, unless otherwise agreed by FWPT in the partial payment agreement.** All partial payments less than the required minimum submitted shall go towards the balanced owed. However, these insufficient partial payments will not prevent the collections process unless outlined specifically in the payment agreement between FWPT and the patient.

Additionally, FWPT may restrict the scheduling of non-emergent and non-urgent services for individuals with delinquent accounts as deemed necessary.
I agree to be responsible for payment of all services rendered on my behalf or that of my dependents. I acknowledge and accept this Financial Policy.

PRINT Patient Name: _____

Signature of Patient: _____
(*Parent or legal guardian must sign if patient is under 18 years of age.*)

Relationship to Patient: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Ferrell Whited Physical Therapy Services reserves the right to modify the privacy practices outlined in the notice. I have received a copy of the Notice of Privacy Practices for Ferrell Whited Physical Therapy Services.

PRINT Name of Patient: _____

Signature of Patient: _____
(Parent or legal guardian must sign if patient is under 18 years of age.)

Relationship to Patient: _____ Date: _____

OFFICE USE ONLY
Documentation of Attempt to Obtain Acknowledgment of Receipt of Privacy Practices Date: _____
The acknowledgment was not obtained because the patient declined to sign the acknowledgment. _____
Other Reason: _____
Name of Patient: _____Name of FWPT Employee: _____

Employer:_____ Occupation_____
(Required for Workers Compensation Cases)

Emergency Contact :_____Phone No._____ Relation_____

CONSENT FOR TREATMENT

I hereby consent to and authorize all therapy treatments, which in conjunction with the judgment of my attending physician, may be considered necessary and/or advisable for the diagnosis and/or treatment of the patient named above at Ferrell-Whited Physical Therapy Services.

Signature:_____ Date:_____

(Parent or legal guardian must sign if patient is under18 years of age)

Relationship to Patient (circle one): Self Mother Father Spouse Legal Guardian

Credit Card Authorization Agreement

Patient Name: _____

Cardholder Name & Relationship to patient:

_____

I, the undersigned, herby authorize Ferrell Whited Physical Therapy Services, to keep my credit card on file for the purpose of paying unpaid insurance balances and any late cancel or no-show fees. By signing below, I agree to allow Ferrell Whited Physical Therapy Servies to store my credit card information and process payments automatically for balances that remain 30 days after statements are mailed. Payments can be made by other means prior to said date.

If the credit card company declines my transaction, I understand that Ferrell Whited Physical Therapy Services will contact me and payment will be required within 2 business days. A $15 fee will be assessed for any declined transactions

This authorization will remain in effect for **one year** from the signed date, after which a new agreement will be completed.

Cardholder Signature:

_____

Date: _____

Credit Card/Debit Card Information:

Card Type

___ Visa

___ Mastercard

___ Discover

___ American Express

___ HSA

Credit Card Number _____

Expiration Date: _____

CVV: _____

Billing Address

Street Address: _____

City_____ State_____ Zip_____

Email: _

_____Phone_____

Important Notice Your credit card information will be entered into a secure payment portal and will **not** be stored in paper format. Once entered, the portion of the form with credit card information will be shredded for security purposes.