If yes to any of the following questions, please see the receptionist for alternate paperwork (please circle)

Is your therapy for a work-related injury? Yes / No
Is your therapy for an auto accident injury? Yes / No
Do you have an attorney/seeking an attorney representation regarding this injury? Yes / No

---

PATIENT DEMOGRAPHICS:

Date: _____

Patient Last Name: _____ Patient First Name: _____

Sex: _____ Email: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell / Home

If Minor, Guardian's Name: _____

Occupation: _____

Referring Physician: _____ Physician Phone: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: _____

How did you hear about us? _____

What are we seeing you for? _____

Have you received therapy/home health from a different provider within the last two months? Yes / No

We provide courtesy appointment reminders. Do you prefer: TEXT / PHONE CALL / EMAIL

LVL UP
PHYSICAL THERAPY

BODY VITALS:

Height: ___' ___"

Weight: _____ pounds

HEALTH INSURANCE INFORMATION:

PRIMARY INSURANCE COMPANY: _____
INSURED'S NAME: _____ INSURED'S DOB: _____
RELATIONSHIP: _____ INSURED'S SSN# _____
POLICY ID#: _____ GROUP# _____

SECONDARY INSURANCE COMPANY: _____
INSURED'S NAME: _____ INSURED'S DOB: _____
RELATIONSHIP: _____ INSURED'S SSN# _____
POLICY ID#: _____ GROUP# _____

❏ **SELF PAY/OUT OF POCKET**

LVL UP
PHYSICAL THERAPY

PLEASE REVIEW THE FOLLOWING NOTICES:

NOTICE OF PRIVACY (HIPAA): I understand that LVL Up Physical Therapy complies with HIPAA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing, and collection pertaining to my care under which my case is closed and full payment is received. I authorize the release of any information pertinent to my case to any insurance company, adjustor, or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me. A photocopy of the assignment is to be considered as valid as the original. Please see attached notice of Privacy Practices. Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

CONSENT TO TREAT: I hereby authorize the professional staff at LVL Up Physical Therapy to examine and treat me with physical therapy for the injury that I have been referred here for or referred myself to.

CANCELLATION AND NO SHOW POLICY: We require a 24 hour notice for cancellations. There is a $25 charge for appointments not canceled in a timely manner and for missed appointments. It is your responsibility to pay for this cancellation fee, it will not be covered by your lien or workers compensation case. By signing this means that you have read and understand our policy.

FINAL POLICY STATEMENT: Insurance: As a courtesy to me, LVL Up Physical Therapy will file claims to my insurance company, but payment for treatment is my responsibility whether my insurance carrier pays. Estimated payment, deductible, and coinsurance or copayments are **MY** responsibility and are due upon services rendered. If my insurance company requests a refund of payments made, I will be responsible for the amount of money refunded to my insurance company. If any payment is made directly to me for services billed by LVL Up Physical Therapy, it is my obligation to promptly send payment to LVL Up Physical Therapy. I understand it is my responsibility to contact my insurance carrier to verify my own benefits to be aware of any contract limitations. I understand that my deductible amount must also be satisfied. I understand that it is my responsibility to inform this office of any changes to my medical insurance status.

Print Name: _____ **Date:** _____

Signature of Patient/Guardian: _____

LVL UP
PHYSICAL THERAPY

CREDIT CARD AUTHORIZATION

In order to provide you and other patients at LVL Up Physical Therapy the best possible care, a minimum of 24 hour notice is required to cancel or reschedule your appointments.

I, _____, understand the importance of notifying LVL Up Physical Therapy at least **24 hours prior to my scheduled appointment** that I am not able to keep my appointment. If I am experiencing an emergency, I will provide as much notice as possible to avoid being charged the “late cancellation” fee of $25. I understand that I will be charged a no show fee of $50 for failing to call and failing to show for my scheduled appointment.

I, _____, give LVL Up Physical Therapy, PLLC the authorization to charge my credit card $25 for each missed therapy session where 24 hours notice is not given and $50 for each missed therapy session where I fail to call and show for the appointment. This credit card will also be used for all fees that have not been paid within 60 days (unless other arrangements for payment have been agreed upon between me and my provider). I will be provided a receipt for all payments upon request. This card may also be used for payment of services upon my request (co-payment, deductibles, and fees).

I understand that I may revoke this agreement at any time by providing a request in writing. I am also aware that when physical therapy services rendered by LVL Up Physical Therapy have ended and all payments have been completed, this form shall be shredded once I am discharged and terminated from services.

I am requesting that this card may be used for payment of services (co-pay, deductibles, other physical therapy fees) _____ Yes _____ No

Patient (or Parent/Guardian) Card Holder Signature:

X_____ **Date:** _____

STAFF OFFICE USE

(PLEASE PRESENT YOUR CREDIT CARD TO THE FRONT OFFICE STAFF)

Name on Card: _____

Card Number: _____

Expiration Date: _____ CVV Code: _____

LVL UP
PHYSICAL THERAPY

GOOD FAITH ESTIMATE

Purpose: The Good Faith Estimate is intended to provide you with an estimate of the charges you'll incur at LVL Up Physical Therapy. Uninsured and self-pay clients are entitled to Good Faith Estimates as of January 1st 2022 under the No Surprises Act.

Providers involved in your care:

- Dr. Evan Bishop, PT, DPT - NPI 1437589264
- Dr. Michaela Rowe, PT, DPT - NPI 1336875947
- Laureina Mathew, PTA - NPI 1174140305

Clinic Fee Structure: Your physical therapy treatment will include an initial evaluation and a combination of treatments that may include manual therapy, exercise, and physical training. If you have any questions about your upcoming appointment, please don't hesitate to reach out before your visit.

The total cost of your care will include the initial visit, plus any follow-up visits, and will be paid as you go. Your first session will be an evaluation, which costs $125, your 10th session will be considered a re-evaluation which costs $125, and follow-up visits are $75 each.

Example of estimated cost:

- Initial Appointment (Evaluation): $125
- Re-Evaluation: $125
- Follow-Up Appointment (as needed): $75

Disclaimer: This Good Faith Estimate shows the costs of items and services that are reasonably expected based on your health care needs. The estimate is based on information known at the time the estimate was created. It does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill. This Good Faith Estimate is not a contract and does not require you to obtain the services or items from the providers or facility identified in it. You have the right to request another Good Faith Estimate at any time during your course of care. If the actual billed service charges exceed this estimate by $400 or more, then you (the patient) have the right to dispute the bill. Please contact our office and speak with the billing department to resolve this matter. If matters need to enter the dispute process, you (the patient) have the right to contact the patient-provider dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill. There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call the No Surprises Help Desk at 1-800-985-3059

Signature of Patient/Guardian: _____

LVL UP
PHYSICAL THERAPY

MANDATORY COVID PRE-SCREENING FORM

1. Do you have a fever? Yes / No
2. Do you have any of the following signs of symptoms?

Sore Throat	Difficulty Swallowing	Unexplained fatigue
Runny Nose/Sneezing	Decrease or loss of sense of smell	Diarrhea
Nasal Congestion	Chills	Abdominal Pain
Hoarse Voice	Headache	Nausea/Vomiting

3. Have you traveled or have had close contact with anyone who has traveled in the past 14 days that was COVID-19 positive? Yes / No

4. Have you had close contact with anyone with respiratory illness or a confirmed or probable/suspected case of COVID-19? Yes / No

5. Did you wear the required and/or recommended PPE according to the type of duties you were performing (e.g., goggles, gloves, mask and gown or N95 with aerosol generating medical procedures when you had close contact with a suspected or confirmed case of COVID-19?
   Yes / No

I knowingly and willingly consent to have physical therapy completed during the COVID-19 pandemic.

I understand the COVID-19 virus has a long incubation period during which carries of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not given the current limit in virus testing.

- _____ (initial) I confirm that I am not presenting any of the following symptoms of COVID-19 listed above.
- _____ (initial) I confirm that I have not cared for or been in contact with someone diagnosed with COVID-19.
- _____ (initial) I understand that air travel significantly increases my risk of contracting and transmitting the COVID-19 virus. And the CDC recommends social distancing of at least 6 feet for a period of 5 days to anyone who has or been in contact with COVID-19, and that this is not possible with physical therapy.

Signature of Patient/Guardian : _____

LVL UP
PHYSICAL THERAPY

MEDICAL RECORDS RELEASE AUTHORIZATION

PATIENT NAME: _____

DATE OF BIRTH: _____ **SSN:** _____

I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF MY PROTECTED HEALTH INFORMATION (PHI) TO THE FOLLOWING. THIS CONSENT AUTHORIZES THE COMMUNICATION OF MY TREATMENT, CARE, BILLING, SCHEDULING, AND MEDICAL RECORDS AS IT PERTAINS TO ME, THE PATIENT/GUARDIAN.

Name of Person/Facility: _____ **Relationship:** _____

Address: _____

Phone: _____ **Fax:** _____

Email: _____

_____

Name of Person/Facility: _____ **Relationship:** _____

Address: _____

Phone: _____ **Fax:** _____

Email: _____

_____

Name of Person/Facility: _____ **Relationship:** _____

Address: _____

Phone: _____ **Fax:** _____

Email: _____

_____

THE FOLLOWING RECORDS IN YOUR POSSESSION CONCERNING MY TREATMENT ON:

- ❑ **ALL DATES OF SERVICE PERFORMED BY LVL UP PHYSICAL THERAPY**
- ❑ **ALL DATES OF SERVICE AFTER DATE OF INJURY:** _____
- ❑ **ALL RECORDS FOR DATES OF TREATMENT:** _____ **TO** _____

[ ] I <u>DO NOT</u> AUTHORIZE ANY OF MY INFORMATION TO BE RELEASED TO ANYONE.

Print Name: _____ **Date:** _____

Signature of Patient/Guardian: _____

LVL UP
PHYSICAL THERAPY

DRY NEEDLING CONSENT TO TREAT FORM

Dry needling (DN) is a skilled technique performed by a physical therapist using filiform needles to penetrate the skin and/or underlying tissue to affect change in body structures and functions, for the evaluation and management of neuromusculoskeletal conditions, pain, movement, impairment, and disability. Like any treatment, there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving your consent for dry needling treatment.

RISK OF THE PROCEDURE

The most serious risk associated with DN is accidental puncture of a lung (pneumothorax). If this were to occur, it may require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe lung puncture, while rare, may require hospitalization. Other risks may include bruising, infection, or nerve injury. **It should be noted that bruising is a common occurrence and should not be a concern.** The monofilament needles are very small and do not have a cutting edge; the likelihood of any significant tissue trauma from DN is unlikely. There are other conditions that require consideration, so please answer the follow questions:

- **Are you taking blood thinners? YES / NO**
- **Are you or is there a chance you could be pregnant? YES / NO**
- **Are you aware of any problems or have any concerns with your immune system? YES / NO**
- **Do you have any known disease or infection that can be transmitted through bodily fluids? YES / NO**
  If yes, please state _____

PATIENT'S CONSENT:

I have read and fully understand this consent form and attest that no guarantees have been made on the success of this procedure related to my condition. I am aware that multiple treatment sessions may be required, thus this consent will cover this treatment as well as subsequent treatments by this facility. All of my questions, related to this procedure and possible risks, were answered to my satisfaction. My signature below represents my consent to the performance of dry needling and my consent to any measures necessary to correct complications, which may result, I am aware I can withdraw my consent at any time.

I, _____ authorize the performance of dry needling.

Print Name: _____

Signature of Patient/Guardian: _____

Today's Date: _____