NEXT ERA
PERFORMANCE. RECOVERY. REHAB.

PATIENT NAME

Legal First Name:_____ Legal Last Name:_____ MI:_____

(If Minor) Parent/Guardian Legal Name:_____ DOB:_____

PATIENT DEMOGRAPHICS

Gender: (Circle One): **M / F** DOB:_____ Occupation:_____

Street Address:_____ City:_____

State:_____ Zip Code:_____ Email:_____

Phone #:_____ Text Reminders: **Y / N** Email Reminders: **Y / N**

Emergency Contact:_____ Phone #:_____

REFERRAL

Have you been seen by a physician? **Y / N** Physician Name and Office:_____

How did you hear about us? _____

WORKER'S COMPENSATION OR AUTO INJURY INFORMATION (If Applicable)

Injury Date:_____ Surgery Date:_____ Auto (circle one): **Y / N** Workers Comp: **Y / N**

Claim Information (If Applicable):_____

Adjuster Name:_____ Phone #:_____ Fax:_____

Next Era Physical Therapy

P: (720) 644-0181
F: (720) 381-6868

6851 S Holly Circle #110
Centennial, CO 80112

www.nexterapt.com

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Do you wish to bill your health insurance for this visit? Yes_____ No_____ (If **YES**, please complete *Section A*. If **NO**, please complete *Section C*).

SECTION A: INSURANCE

Insurance Provider:_____

Policy Holder:_____

DOB of Policy Holder:_____

SECTION B: DRY NEEDLING FEE

There is no current procedural code for Dry Needling, thus, we are currently unable to directly bill your insurance for Dry Needling and require a separate fee in addition to your copay/coinsurance. This fee is used to cover the expense of needling supplies, training, and other costs associated with providing this service.

Dry Needling Fee: $29.00

SECTION C: PHYSICAL THERAPY DISCOUNT PACKAGES

The following Discount Packages are available for purchase in lieu of utilizing an insurance plan for payment. You must agree to the terms stated in our financial policy. Prices are subject to change without notice.

Single Visit: $109.00
✓ ONE 30-minute evaluation/re-evaluation and treatment. Home exercise review.

Physical Therapy 5 Pack: $499.00
✓ FIVE 30-minute evaluations/re-evaluations and treatments. Home exercise review.

Physical Therapy 10 Pack: $899.00
✓ TEN 30-minute evaluations/re-evaluations and treatments. Home exercise review.

Signature: _____ | Date: _____ / _____ / _____

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HISTORY

Exercise Frequency:_____ Exercise Type(s):_____

Do you smoke? **Y / N** Have you ever smoked? **Y / N** How often?_____

Are you pregnant?_____ Do you have a Pacemaker? **Y / N**

Allergies:_____

What medications are you currently using?_____

Previous complaints/surgeries:_____

Previous diagnoses/medications:_____

COMPLAINT

What is your major complaint?_____ Start Date:_____

Symptoms?_____ Possible Cause:_____

Previous doctors seen for complaint:_____

Previous treatment for complaint:_____

Symptom-Aggravating Factors:_____

Symptom-Relieving Factors:_____

Time of Day Symptoms Are Best:_____ Worst:_____

Current Duration of Pain (Check applied): _____Intermittent _____Constant _____With Certain Moves

Current Level of Pain (Check applied): _____Mild _____Moderate _____Severe _____Excruciating

Is your pain getting better or worse?_____ Have you had this injury before? **Y / N**

DO YOU HAVE ANY OF THE FOLLOWING TODAY? (Check all that apply)

▢ AIDS/HIV	▢ Anemia	▢ Angina	▢ Arteriosclerosis
▢ Arthritis	▢ Asthma	▢ Blood Clots	▢ Bone Infection
▢ Chemical Dependency	▢ Cancer	▢ Circulation Problems	▢ Depression
▢ Diabetes	▢ Epilepsy	▢ Eye Infection	▢ Heart Problems
▢ Hemophilia	▢ High/Low Blood Pressure	▢ Joint/Bone Infection	▢ Liver Problems
▢ Lung Issues	▢ Multiple Sclerosis	▢ Musculoskeletal Problems	▢ Pneumonia
▢ Stroke	▢ STD	▢ Tuberculosis	▢ Urinary Infection

MARK AREAS OF DISCOMFORT


FRONT


SIDE


SIDE


BACK

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ATTENDANCE POLICY

Your adherence to the recommended number of treatments is a vital component of your progress with our services. We feel it is our duty to do everything within our power to emphasize the importance of your commitment.

Reminder emails/texts/calls:

While we provide automated appointment reminders as a courtesy, ultimately, the responsibility for remembering your appointments is YOURS.

Late Policy:

If you are less than 15 minutes late and have called to warn us that you'll be late, you may complete the remaining time scheduled for your session, knowing that you will not receive a full session. If you are more than 15 minutes late and have not contacted our office, we hold the right to consider your appointment a "No-Show." As per the Cancellation/No-Show Policy, we reserve the right to charge a $75 cancellation fee.

Cancellation/No-Show Policy:

As a professional courtesy to our office and our Doctors, **WE RESERVE THE RIGHT TO CHARGE A $75 CANCELLATION FEE** If you cancel **WITH LESS THAN 24 HOURS** of your appointment. This is also a courtesy to patients who are on the waitlist who are needing to schedule appointments. While we understand that problems will arise, keeping your appointments is crucial to your ongoing care for the following reasons:

1) **In order to help you achieve your goals, you must follow the plan prescribed by your Doctor of Physical Therapy**

2) **Physical Therapy is a process and it is difficult to maintain progress with poor attendance.**

3) **Poor attendance will likely result in extended treatment plans, effectively costing you more time and money.**

Signature: _____ | Date: _____ / _____ / _____

Guardian Signature: _____ | Date: _____ / _____ / _____

FINANCIAL POLICY

The following is the Next ERA Physical Therapy LLC financial policy. To ensure continuity of care that is not impacted by financial misinterpretations, Next ERA Physical Therapy LLC has firm guidelines on the preparation and handling of insurance claims. Therefore, we require that you read and sign this prior to treatment. Please do not hesitate to ask any questions.

Introduction

Upon your first visit, we will ask for your complete insurance information, a copy of your insurance card, and a copy of your photo ID (driver's license). **Your policy is an agreement between you and your insurance provider. We will do our best to help you determine the benefits of your plan, but it is your responsibility to fully understand your individual contract.**

Adults must accompany minors (anyone under 18 years of age) for the first visit to provide consent to treat, and are also responsible for payment of services during the duration of care.

Billing Policy

At this time, Next ERA Physical Therapy LLC is a preferred provider for **MOST** healthcare services, meaning we are in-network with this insurance provider. Most out-of-network policies have both in-network and out-network benefits, so we will check your benefits and quote you the amount that applies to your policy. Claims will be submitted to out-of-network insurance on the patient's behalf as a normal claim, but the patient may end up owing the full out of network rate of $109.00. We are currently In-Network with **MOST** Humana, UMR, Cigna, United, Tri-Care, BCBS, Aetna and Medicare replacement plans. For a full list of providers please inquire.

Medicare

We are a participating provider for Medicare. Medicare will require a physician's referral for physical therapy before they reimburse Next ERA Physical Therapy LLC for your treatments. Medicare will pay 80% of the charges at this clinic until your yearly cap is met. You are also responsible for paying any deductible and/or any charges incurred after your yearly cap has been met.

Claims Submission

Next ERA Physical Therapy LLC assists in claims preparation and guidance for self-claims, but is not responsible for denial or re-adjustment of claim's billed amounts, reimbursement rates, or benefits. Estimated benefits and reimbursement are the responsibility of the insurance carrier and the patient.

Payment Agreement

It is our policy to maintain your account on a current basis. Charges for treatment are due at the time the service is provided unless otherwise deemed necessary and agreed upon in writing. If a Physical Therapy treatment package is selected, the package must be paid **IN FULL** at the time of the first visit. Physical Therapy treatment packages are valid for **ONE YEAR** from the date of purchase. Treatment packages are **NON-REFUNDABLE** for any unused visits.

It is our policy that if you should choose to suspend or terminate your care and treatment, any outstanding fees for professional services rendered to you will be immediately due and payable. If your account becomes delinquent, collection proceedings will occur and you will be charged a collection fee of $250.00 for each month that you have a balance in collections. If your case goes to court, you will be responsible for any attorney fees and/or court costs incurred.

I HAVE READ AND AGREE TO THE ABOVE DISCLOSURES AND AGREEMENTS.

Print Name: _____

Signature: _____ | Date: _____ / _____ / _____

Guardian Signature: _____ | Date: _____ / _____ / _____

PRIVACY and SECURITY of HEALTH INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Legal Requirements:

The law requires that we:

1) Keep your medical information private

2) Give you notice describing our legal duties and privacy practices

3) Notify you of any changes in our privacy practices.

Treatment:

We may use your medical information to provide you with medical treatment or other services related to your care. We may disclose your medical information to doctors, nurses, technicians or other healthcare providers that are directly involved in your care.

Release of Medical Information; Acknowledgement of Understanding

By signing below, I authorize the release of medical information necessary to my care, as determined by my physical therapist or other provider, to healthcare providers directly related to my care.

Print Name: _____

Signature: _____ | Date: _____ / _____ / _____

Guardian Signature: _____ | Date: _____ / _____ / _____

SOCIAL MEDIA & TESTIMONIAL RELEASE

I, _____, hereby consent to allow Next ERA Physical Therapy LLC and its employees, agents, partners, and affiliates (collectively "Clinic"), to use my name, photograph, videotape/audiotape recording, and/or written testimonial ("Marketing Materials") in Clinic's marketing brochures, publications, and/or on their website and any social media accounts to promote the services offered by Clinic. I understand and agree that these Marketing Materials are owned by the Clinic and will not be returned to me.

I hereby release, hold harmless, and forever discharge the Clinic from any and all claims, demands, and causes of action which I have or may have by reason of this authorization.

Further, I hereby affirm that I have read this Consent to Likeness and Release, and I fully understand the content, meaning, and impact of this agreement. This agreement shall be binding upon me and my heirs, legal representatives and assigns.

Signature: _____ | Date: _____ / _____ / _____

Guardian Signature(If patient is a minor): _____ | Date: _____ / _____ / _____