



# 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: \_\_\_\_\_

Patient Phone #: \_\_\_\_\_ Patient Email: \_\_\_\_\_

Text Reminders: **Y / N**

Email Reminders: **Y / N**

Parent Phone #: \_\_\_\_\_ Parent Email: \_\_\_\_\_

Text Reminders: **Y / N**

Email Reminders: **Y / N**

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

## REFERRAL

Have you been seen by a physician? **Y / N** Physician Name & Office: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

## WORKER'S COMPENSATION / AUTO INJURY INFORMATION (If Applicable)

Injury Date: \_\_\_\_\_ Surgery Date: \_\_\_\_\_ Work Comp? **Y / N** Auto Injury? **Y / N**

Claim Information (If Applicable): \_\_\_\_\_

Adjuster Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

## Next Era Physical Therapy

P: (720) 644-0181

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Centennial, CO 80112

[www.nexterapt.com](http://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:\_\_\_\_\_

Policy Holder D.O.B.:\_\_\_\_\_

## SECTION B: DRY NEEDLING FEES

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 Per Session**

## SECTION C: PHYSICAL THERAPY PACKAGE DISCOUNTS

The following Package Discounts 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. ***Dry needling not included.***

**Initial Assessment: \$139.00**

- Required for ALL Treatment Plans

**Single Visit: \$129.00**

**Physical Therapy 5 Pack: \$599.00**

**Physical Therapy 10 Pack: \$999.00**

Signature:\_\_\_\_\_

Date:\_\_\_\_\_

Guardian Signature (If Minor):\_\_\_\_\_

Date:\_\_\_\_\_



## 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: \_\_\_\_\_

## COMPLAINTS

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

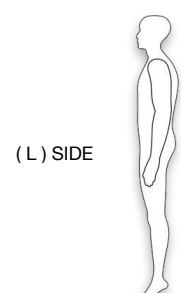
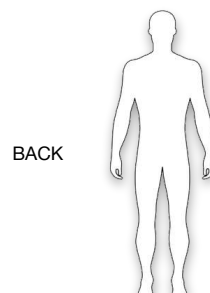
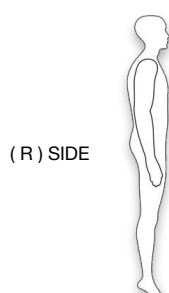
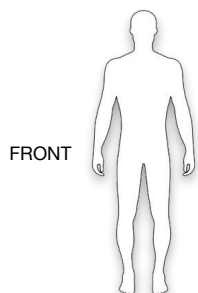
Current Level of Pain (Check applied): \_\_\_\_\_ Mild \_\_\_\_\_ Moderate \_\_\_\_\_ Severe \_\_\_\_\_ Excruciating

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)

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> AIDS/HIV            | <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Angina                   | <input type="checkbox"/> Arteriosclerosis  |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Blood Clots              | <input type="checkbox"/> Bone Infection    |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Circulation Problems     | <input type="checkbox"/> Depression        |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Eye Infection            | <input type="checkbox"/> Heart Problems    |
| <input type="checkbox"/> Hemophilia          | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Joint/Bone Infection     | <input type="checkbox"/> Liver Problems    |
| <input type="checkbox"/> Lung Issues         | <input type="checkbox"/> Multiple Sclerosis      | <input type="checkbox"/> Musculoskeletal Problems | <input type="checkbox"/> Pneumonia         |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> STD                     | <input type="checkbox"/> Tuberculosis             | <input type="checkbox"/> Urinary Infection |

## MARK AREAS OF DISCOMFORT





**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 \$75.00 cancellation fee.

**Cancellation/No-Show Policy:**

While we understand that situations 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 of care agreement established between you and 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.
4. We reserve the right to charge a \$75.00 cancellation fee and/or terminate your plan of care for cancellations less than 24 hours of scheduled appointment time.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Guardian Signature (If Minor): \_\_\_\_\_

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 an in-network provider for **MOST** insurance carriers. Claims will be submitted on the patient's behalf as a normal claim, but the patient may end up owing the full rate of \$129.00. We are currently In-Network with **MOST** Humana, UMR, Cigna, United, Tri-Care, BCBS, Aetna and Medicare replacement plans. For a full list of payers please inquire.

### Medicare

**We are a participating provider for Medicare.** Medicare will require a physician's referral for physical therapy prior to your treatments. A deductible will apply to all Medicare plans. 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 and cannot be shared. Treatment packages are **NON-REFUNDABLE** for any unused visits.



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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.

### **Pre-Authorization**

Prior authorization may need to be obtained in order to use your benefits. Next Era Physical Therapy LLC will submit for prior authorization according to the guidelines set forth in your plan. Should authorization fail to be obtained OR be denied, you will be responsible for the self payment rate of \$129.00.

### **Credit Card Service Fee**

We impose a surcharge of **3.5%** on the transaction amount on ALL credit card purchases, which is not greater than our cost of acceptance. We do not surcharge debit cards.

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

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Guardian Signature (If Minor): \_\_\_\_\_

Date: \_\_\_\_\_



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**PRIVACY & 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.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Guardian Signature (If Minor): \_\_\_\_\_

Date: \_\_\_\_\_



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**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 Minor): \_\_\_\_\_

Date: \_\_\_\_\_