IMPORTANT: PLEASE READ CAREFULLY!

Basic Financial Policy

Dear Patients,

Every insurance policy is different, so we ask that you verify your physical therapy benefits with your insurance company prior to initiating treatment so that you may address any questions about your policy directly with the insurance carrier. ***It is our policy to collect any payments that you, as a patient, are responsible for per your insurance contract at the time of service on each visit***. Please be prepared to make a payment at the time you check in/out. If you have an unmet deductible or coinsurance applies, your costs will be calculated at the end of your visit, so please be sure to stop by the front desk to make a payment and schedule future visits. Payment in full is expected for services rendered. We accept cash, check, debit cards, Master Card and Visa.

We will be happy to address any questions about your approximate cost per visit to the best of our ability, though sometimes there will be inaccuracies in what we collect from you due to pending claims from other provider visits and variances in insurance allowed amounts. If after claim submission your insurance company's Explanation of Benefits shows a different patient responsibility amount from what we collected from you, we will either send you a refund for overpayment or a bill for any remaining balance.

If you are experiencing financial difficulties or are concerned about costs, you must ask before treatment is rendered and we will arrange a payment plan that suits your specific financial situation. You will need to provide a credit card to keep on file that will be charged automatically on a recurring basis as scheduled until the balance is paid in full.

You agree that in order for us to service your account or to collect any amounts you owe, we may contact you by telephone at any phone number associated with your account, including wireless telephone numbers, which may result in charges to you. We may also contact you by sending text messages or via email, using any email you provide. Methods of contact may include using pre-recorded/ artificial voice messages and/or use of an automatic dialing device, as applicable.

If your account is placed with a collection agency you will be responsible for a collection fee of 35% of the amount transferred for recovery. If legal action is taken on your account, you will also be responsible for any court costs and/or attorney fees incurred in the legal process.

By signing below, I acknowledge that I have read and understand the above statements and agree to abide by the financial policy or otherwise make alternate financial arrangements prior to initiating my treatment.

Patient Signature: _____ Date: _____

Print Name: _____

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OUTPATIENT THERAPY TREATMENT AGREEMENT

NAME: *(Last)* _____ *(First)* _____ *(Middle Initial)* _____

SS#: __ __ __ - __ __ - __ __ __ __ Address: _____

DOB: __ __/__ __/__ __ __ __ City: _____ State: _____ Zip: _____
M M D D Y Y Y Y

Marital Status: S M Other **Sex**: M F **Primary Phone**: _____ **Alt Phone**:_____

Email:_____Employer: _____ Work Phone: _____

INJURY DATE/ ONSET OF SYMPTOMS: __ __/__ __/__ __ __ __
M M D D Y Y Y Y
*** Is this injury related to a work or motor vehicle accident? **YES / NO**

REFERRING PHYSICIAN: _____ DATE OF LAST DR.VISIT:__ __/__ __/__ __
M M D D Y Y

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

RESPONSIBLE PARTY: _____ DOB: __ __/__ __/__ __ __ __
M M D D Y Y Y Y

SS#: __ __ __ - __ __ - __ __ __ __ Employer: _____

Address: _____City: _____ State: _____ Zip: _____

Home: _____ Work Phone: _____Cell Phone: _____

EMERGENCY CONTACT: _____Relationship: _____

Address: _____City: _____ State: _____ Zip: _____

Primary Phone:_____ Work Phone: _____Cell Phone: _____

Whom we should thank for referral: _____

***IMPORTANT! PLEASE READ AND INITIAL**

I hereby authorize any insurance company to pay the proceeds of any benefits due to be directly sent to Beyond Physical Therapy, PLLC, 9257 Middlebrook Pike, Knoxville, TN 37931. I acknowledge and understand that I am responsible for all charges for all the services rendered to me or to any member of my family even though I have requested insurance billing on my behalf. By providing my email address I am opting to receive notices and E-newsletters from Beyond Physical Therapy.

_____

I agree to make payment in full of my portion not paid by insurance (deductible, co-pay, co-insurance, non-covered items) within 30 days from the date of the first bill unless otherwise arranged with the Business Manager of BPT. After that period the unpaid balance will increase by 20% and further delay over 60 days will cause a 30% increase of the balance. Accounts older than 90 days will be transferred to a collection agency at my expense of 40% of the balance. Please be courteous and cancel or reschedule appointments 24-hours in advance.

I have personally or through my physician requested rehabilitative services. I hereby authorize release of medical records to other medical agencies or my attorney as necessary.

I certify that the information given to file for insurance payment is correct, and I request such payment to be made directly to Beyond Physical Therapy, PLLC.

Scan with your smartphone to sign up for our newsletter!

_____ _____
Patient or responsible party signature *Date*

Beyond Physical Therapy, PLLC

Patient Name:_____ **Date**__ __/__ __/__ __

FAMILY/PERSONAL HISTORY

Family History

Have you or any immediate family member (parent, sibling, child) ever been told you have:			**Relation to Client**
• Angina or chest pain	Yes	No	
• Cancer	Yes	No	
• Diabetes Type I or Type II	Yes	No	
• Heart Attack	Yes	No	
• Hemophilia/ slow healing	Yes	No	
• High cholesterol	Yes	No	
• Hypertension or high blood pressure	Yes	No	
• Stroke	Yes	No	

Personal History

Please check all that apply if you have ever had:

☐ Epilepsy/ seizures
☐ Anxiety/ Panic Attacks
☐ GERD
☐ Osteoporosis
☐ Blood Transmitted Diseases (HIV, Hepatitis)
☐ Osteoarthritis
☐ Polio/postpolio
☐ Rheumatic Arthritis
☐ Ulcer/stomach
☐ Cirrhosis/liver disease
☐ Fibromyalgia/myofascial pain
☐ Ligamentous laxity
☐ Mental/behavioral disorder
☐ Gout
☐ Anti-coagulant medication
☐ Prolonged oral steroid medication
☐ Peripheral vascular disease or anomalies
☐ Malignancies
☐ Urinary incontinence (dribbling, leaking)
☐ Kidney disease/stones
☐ **NONE APPLY**

For women:

History of endometriosis Yes No
History of pelvic inflammatory disease Yes No
Are you/could you be pregnant? Yes No

General Health:

1. I would rate my health as (circle one): Excellent Good Fair Poor

2. Have you had any illnesses within the past 3 weeks (e.g. colds, influenza, etc.)? Yes No
   If yes, have you had this before in the last 3 months? Yes No
3. Have you noticed any lumps or thickening of the skin or muscle anywhere on your body? Yes No
4. Do you have any sores that have not healed, or noticed any changes in size, shape or color of a wart or mole? Yes No

5. Have you had unexplained weight gain or loss in the last month? Yes No

6. Do you smoke or chew tobacco? Yes No

If yes, how many packs/pipes/pouches/sticks a day?_____

7. I used to smoke/chew, but I quit Yes No

If yes, amount per day:_____

8. How much alcohol do you drink in the course of a week? _____ (one drink is equal to 1 beer, 1 glass of wine, or 1 shot of hard liquor)

9. Do you use recreational or street drugs (marijuana, cocaine, meth, amphetamines, or others)? If yes, what, how much, how often? Yes No

_____

10. Are you on a special diet? Yes No

11. Do you have any infections of any kind? Yes No

Please check any symptoms that apply:

- ☐ Blood in urine, stool, mucous
- ☐ Dizziness, fainting, blackouts
- ☐ Fever, chills, sweats (day or night)
- ☐ Nausea, vomiting, loss of appetite
- ☐ Changes in bowel or bladder
- ☐ Unusual fatigue, drowsiness
- ☐ Sudden weakness
- ☐ **NONE APPLY**
- □ Throbbing sensation
- □ Trouble sleeping
- □ Memory loss
- □ Numbness or tingling
- □ Confusion
- □ Problems seeing or hearing
- □ Difficulty swallowing/speaking

Medical/Surgical History

1. Have you ever been treated with chemotherapy, radiation therapy, biotherapy, or brachytherapy (radiation implants)? If yes, please describe: Yes No

2. Have you had any x-rays, sonograms, computed tomography (CT) scans, or Magnetic Resonance Imaging (MRI) or other imaging done recently? Yes No

If yes, what? When? Results?

3. Have you had any laboratory work done recently (urinalysis or blood tests)? Yes No

If yes, what? When? Results?

4. Any other clinical tests? Yes No

Please describe:

5. Please list any surgery/operations that you have ever had and the date(s):

Operation	Date
1. _____	_____
2. _____	_____
3. _____	_____

6. Do you have a pacemaker, transplanted organ, joint replacement, breast implants, or any other implants? If yes, please describe: Yes No

Work/Living Environment

1. Does your work involve:
   - ☐ Prolonged sitting (e.g., desk, computer, driving)
   - ☐ Prolonged standing (e.g., equipment operator, sale clerk)
   - ☐ Prolonged walking (e.g., mill worker, delivery service)
   - ☐ Lifting, bending, twisting, climbing, turning
   - ☐ Other: please describe
     _____
   - ☐ Not applicable; none of these

2. Do you use any special supports:
   - ☐ Back cushion, neck cushion
   - ☐ Back brace, corset
   - ☐ other kind of brace or support for any body part
   - ☐ None; not applicable

History of falls:

- ☐ I have had no falls
- ☐ I have fallen once in the past year and was not injured
- ☐ I have fallen once in the past year, resulting in an injury
- ☐ I have just started to lose my balance/fall
- ☐ I have fallen twice or more in the past year
- ☐ I fall frequently (twice or more in the past 6 months).
- ☐ Certain factors make me cautious (e.g., curbs, ice, stairs, getting in and out of the tub).

I live:

□ Alone □ with family, spouse, partner □ Nursing home □ Assisted Living
□ Other _____

Dwelling: □ Apartment □ House □ Trailer □ Stairs □ Steep driveway

Transportation: □ Self-drive □ Public transportation □ Friends/ family drive me

Have you participated in Physical Therapy in the past?

□ No
□ Yes, for my current condition
□ Yes, but not for my current condition
Please list what you have been seen for and when:

Are you taking any prescription or over-the-counter medications? Yes No
If yes, please list:

Acknowledgement of Receipt of Privacy Practices

A copy of our Privacy Practices is available at www.beyondphysicaltherapy.com.

By signing below I, (print name) _____ , birthdate:__ __/__ __/__ __, acknowledge that I have read **Beyond Physical Therapy, PLLC**'s Notice of Privacy Practices.

Signature of Patient_____ Date:__ __/__ __/__ __

Signature of Witness_____ Date:__ __/__ __/__ __

Beyond Physical Therapy, PLLC

Patient Name:_____ **Date**__ __/__ __/__ __

LATE CANCELLATION AND MISSED APPOINTMENT POLICY
PHONE: 865-566-0100

Dear Patient:

Late cancellations and missed appointments interfere with your progress in treatment, as well as scheduling, with respect to the other patients.

It is Beyond Physical Therapy's policy that you, as the patient, are held responsible for all appointments scheduled. If you choose **NOT** to keep your appointments and do **NOT** call to cancel them, you will be charged for the missed visits. The following stipulations apply to this policy:

- **24 HOURS NOTICE, (1 BUSINESS DAY), IS REQUIRED TO CANCEL A SCHEDULED APPOINTMENT**
- **FOR LATE CANCELLATIONS OR MISSED APPOINTMENTS, YOU WILL BE CHARGED $25.00 .**
  (This fee is not covered by your insurance)
- **IF TWO (2) VISITS ARE MISSED (INVALID EXCUSES GIVEN)* YOU WILL BE DISCHARGED AND YOUR DOCTOR WILL BE NOTIFIED.**

*Beyond Physical Therapy understands that exceptional situations occasionally occur. In these circumstances our therapists will personally review requests for cancellations where late or no notice was given.

*****By signing below you acknowledge that you have read, understand and agree to these terms.*****

Patient/ Guardian signature: _____ Date: _____

Please list any person or persons other than your medical providers that we have your permission to release information to:

Name	Relationship
Name	Relationship
Name	Relationship
Name	Relationship