POLESTAR®
PHYSICAL THERAPY
& PILATES CENTER

PERSONAL INFORMATION

Patient Information PLEASE PRINT LEGIBLY				
Last Name		First Name	Middle Initial	Gender
Date of Birth	Age	Weight	Height	
If Patient is under 18, Parent/Guardian Last Name		Parent Guardian First Name		
Primary Phone ☐ Cell ☐ Home ☐ Work		Secondary Phone: ☐ Cell ☐ Home ☐ Work		
Email:				
LOCAL ADDRESS				
Street Address, City, State, Zip, Country				☐ *Use this as mailing address*
Phone:				
PERMANENT ADDRESS				
Street Address, City, State, Zip, Country				☐ *Use this as mailing address*
Phone:				
EMERGENCY CONTACT				
Last Name	First Name	Middle Initial	Relationship	
Street Address, City, State, Zip, Country				
Primary Phone ☐ Cell ☐ Home ☐ Work		Secondary Phone: ☐ Cell ☐ Home ☐ Work		
Email:				
REFERRING PHYSICIAN				
Last Name	First Name	Middle Initial	Specialty	
Office Phone			Office Fax:	
INSURANCE				
Insurance Carrier		Subscriber Name		
Group Number	ID Number	Date of Birth – Primary Holder of the Insurance (mm/dd/yyyy)		

Patient Signature: _____ Date_____

Parent/Guardian Signature: _____ Date_____

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MEDICAL HISTORY

CURRENT CONDITION(S)/CHIEF COMPLAINT(S): Describe the symptoms for which you seek physical therapy. _____

_____

_____

What date did the symptoms begin? _____/_____/_____

Is this the result of an injury? ☐ Yes ☐ No Date of Injury: _____

Was the injury: ☐ Accident ☐ Work Related ☐ Auto Accident

_____

_____

Have you ever had the symptoms before? ☐Yes ☐No What did you do for the symptoms? _____

Did the symptoms get better? ☐Yes ☐No About how long did the symptoms last? _____

What makes the symptoms better? _____

_____

What makes the symptoms worse? _____

_____

What are your goals for physical therapy? _____

_____

_____

Exercise: Exercise beyond normal daily activities and chores? ☐Yes ☐No Average how many days per week do exercise? _____

How any minutes on an average day? _____ Describe the exercise: _____

Marital Status: _____

Living Arrangements: ☐ House ☐ Apartment My living environment has: ☐ Stairs ☐ Elevator

I am currently working: ☐ Yes ☐ No ☐ Full Time ☐ Part Time

Medical History

Existing or Relevant Previous Conditions

Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinson's	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High/Low Blood Pressure	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No		

Describe any other conditions

If "Yes" to any of the above, please explain and give approximate dates/Describe any other Conditions

Fall History

Injury as a result of a fall in the past year? Yes◯

No

Two or more falls in the last year? Yes◯ No ◯

Patient is at risk for falls? Yes◯ No ◯

Surgical History

Body Region:_____Surgery Type:_Date:_____,_____, _____

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: _____

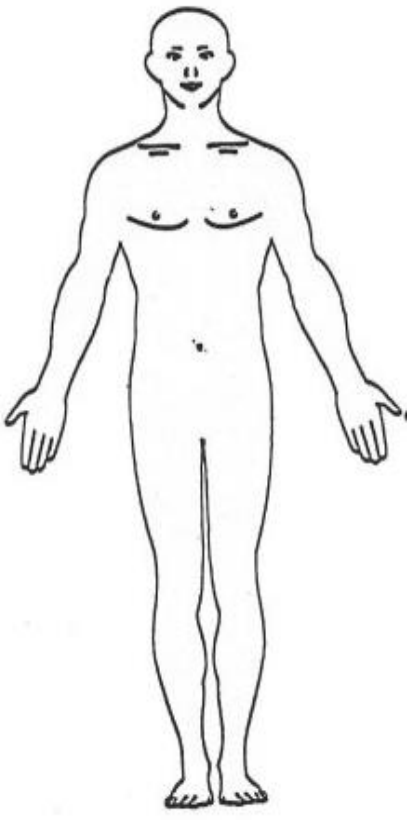
Drug:_____Dosage:_____Frequency:_____Route:_____Reason Taking: _____

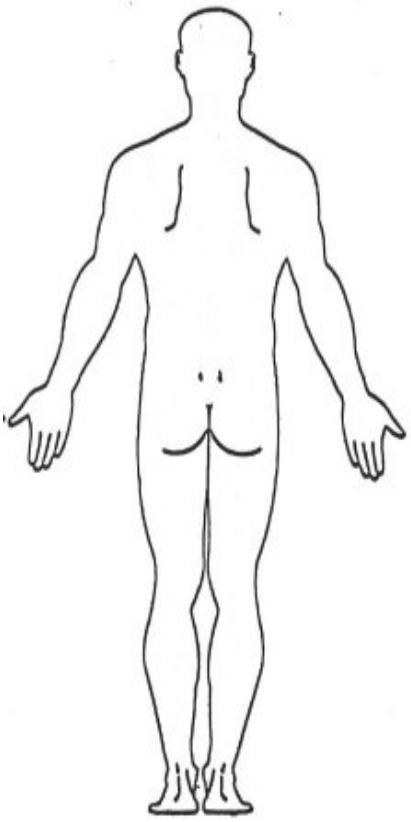
YOUR PAIN TODAY (please circle closest number):

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Pain Imaginable

KEY

1	RED	Pain
2	Green	Discomfort
3	Blue	Aching
4	Orange	Pins and needles
5	Yellow	Tingling
6	Brown	Numbness
7	Black	Radiating
8	Purple	Other





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GENERAL CONSENT FOR TREATMENT

PATIENT NAME: _____ **TODAY'S DATE:** _____

Please Initial next to each statement.

— I consent to undergo all necessary physical therapy treatments and procedures known to improve my condition/diagnosis by the Physical Therapist.

— I have been told the name of the Physical Therapist who has primary responsibility for my treatment and care, as well as other professionals that may be involved in my care.

— I am aware that the practice of Physical Therapy is not an exact science, and I acknowledge that no guarantees have been made to me as to the results of my diagnosis/condition, and physical performance status.

— I hereby authorize Polestar Physical Therapy & Pilates Center to take such still photographs, motion pictures, television transmission and/or videotaped recording for educational and evidentiary purposes as they wish. Any such still or video images used for medical, scientific, research, or educational purposes, will not reveal, where possible my identity through the image itself or the accompanying descriptive text.

— I consent to the release of my medical information and records to other health care providers and physicians, this being necessary for the purpose of my diagnosis/condition.

— I hereby authorize payment directly to Polestar Physical Therapy & Pilates Center. I agree that a scanned or faxed copy or transmission of this authorization is as valid as the original.

It is **essential that you provide a current prescription** for your treatment prior to your first visit. We need your help in securing a new prescription from your doctor if your treatment lasts for more than 30 days. Please ask your therapist for the renewal date of your prescription so that we can insure continuity of treatment.

I am fully aware of my diagnosis and prognosis and I consent to treatment by Polestar Physical Therapy and Pilates Center.

Patient Signature: _____ Date_____

Parent/Guardian Signature: _____ Date_____

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PATIENT FINANCIAL RESPONSIBILITY POLICY NOTICE

PATIENT NAME: _____ **TODAY'S DATE:** _____

PATIENT FINANCIAL RESPONSIBILITY POLICY NOTICE
We would like to make the billing and payment process for services as simple as possible. Please read the following information regarding the financial policies of this office and **initial the source of payment** indicating how your services will be reimbursed.

_____ 1. **SELF PAY WITH PRIVATE INSURANCE**: Professional services rendered to you (or your dependants) by Polestar Pilates LLC (Polestar) are your sole financial responsibility. Polestar does not accept assignment of benefits from your insurer. Polestar will bill your insurance as a courtesy, but you are responsible for payment on the day of service for your treatment. Your insurance company will be asked to reimburse you directly. You are responsible for knowing the benefits of your insurance contract for services rendered to you by Polestar (i.e., out-of-network benefits, deductibles, coinsurance, etc.). **On occasion, an insurance company may send the check for services directly to Polestar. If this happens, Polestar will promptly issue a check to you for the reimbursement amount.**

_____ 2. **SELF PAY WITHOUT INSURANCE**: Professional services rendered to you (or your dependants) by Polestar Pilates LLC (Polestar) are your sole financial responsibility. You are responsible for payment on the day of service for your treatment.

_____ 3. **WORKER'S COMPENSATION OR AUTOMBILE ACCIDENT:** If you were injured during the course of your employment or in an automobile accident, please notify the front office so that you may complete the appropriate paperwork. We will need to contract the insurance carrier to obtain authorization to threat you. We must also confirm and accept your benefits prior to your initial evaluation.

_____ 4. **MEDICARE**: If Medicare is your primary insurance, we will bill Medicare directly. You are agreeing to assign your benefits to Polestar. Medicare only pays 80% so you can either provide us with your secondary insurance information or make a co-payment as follows $36 for an initial evaluation, $26 for a follow up and $13 for half hour. Please note, if you have secondary insurance, you agree to link it electronically to Medicare.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. So, you will be asked to sign an ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE form. This form acknowledges your financial responsibility for expenses Medicare does not cover (e.g., physical therapy, which exceeds the annual maximum benefit). The front office will ask you to sign this form.

* Please direct any additional questions to the business office. It is customary to pay for services at the time they are rendered. For your convenience, payments may be made by cash, check or credit card.

** Please refer to policies for schedule fees, scheduling policies and cancellation policies.

I, THE UNDERSIGNED, HAVE READ THE ABOVE INFORMATION AND UNDERSTAND MY FINANCIAL OBLIGATION TO POLESTAR.

_____ _____
Patient (or Guardian) Signature Date

_____ _____
Witness Signature Date

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POLICIES
Fees, Payment, Scheduling and Cancellation

PATIENT NAME: _____ **Today's Date**: _____

CANCELLATIONS

Cancellations must be made at least **24 hours in advance** to avoid being charged for your session to your credit card. Calling 24 hours in advance allows us to place another person waiting to be seen in your time slot. Failure to show up or call will result in a full charge.

LATE POLICY

Please call if you are running late. If we have not heard from you within 15 minutes after the scheduled starting time, the session will be considered a cancellation.

SCHEDULING

Therapy sessions will be scheduled based on client's requests and therapist's availability. Consistent cancellations of scheduled therapy sessions will result in forfeiture of preferred time slot.

FEES

Initial Evaluation (50 minutes)	$ 175.00
Treatment Sessions (50 minutes)	$ 140.00
Treatment Sessions (25 minutes)	$ 70.00
Advanced Practitioner Additional Fee per 50 minutes**	$ 85.00
Advanced Practitioner Additional Fee per 25 minutes**	$ 50.00

** Brent Anderson & Carol Davis**
Advanced Practitioner Fee is not covered by health plans or insurance

PAYMENT

- Single Consultation prices are to be paid on the day of consult.
- Single Initial evaluation fee is to be paid on the day of first visit.
- Follow up visits can be paid per visit or you may provide credit card information and charges will be processed the day of services received.
- Cancellation fees must be paid before your next scheduled session.
- Packages are prepaid and non-refundable.
- Credit cards, cash and checks are accepted.

COURTESY BILLING

Out of network benefits.
Courtesy billing will be completed for all paid visits.
* Please refer to the "Patient Financial Responsibility Policy Notice"

APPOINTMENT REMINDER

We will send you an appointment reminder 24 hours prior to your scheduled appointment.
Please indicate your preference:

□ Text message to _____

□ Email to _____

I, THE UNDERSIGNED, HAVE READ THE ABOVE INFORMATION AND UNDERSTAND THE POLICIES.

Patient Signature: _____ Date_____

PATIENT NAME: _____ **Today's Date**: _____

HIPAA
RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

I _____ have reviewed/received a copy of Polestar Pilates Center's Notice of Private Practice. I hereby permit (please check):

- ☐ The release of medical or other information to process claims made to insurance.
- ☐ The assignment of payment.
- ☐ The permission to leave a message on my answering machine or voicemail.
- ☐ The permission to discuss my medical condition with another designated individual.

_____ _____
Patient Signature Date

_____ _____
Patient's Guardian Signature Date

I attempted to obtain patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

DATE: _____

Witness Signature: _____

REASON: _____