



Loudoun Sports Therapy Center

The Leader in Physical Therapy

Patient First Name: _____ MI: _____ Last Name: _____

Date of Birth: ____/____/____ Age: _____ Sex (M/F): _____ Preferred Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Phone: _____

Emergency Contact & Phone: _____

If the patient is under age of 18, please fill out the information below:

Guarantor Name: _____ Phone: _____

Address (if different from patient): _____

Please answer the following questions, if they are applicable, about the reason you are here today

Referring Physician: _____ Office Location: _____ Phone: _____

Primary Physician: _____ Office Location: _____ Phone: _____

Is the condition that brought you here today related to (check all that apply):

☐ Work Injury ☐ Auto Accident ☐ Sport Related Injury ☐ Surgery ☐ Other: _____

Injury/Accident/Surgery Date: _____ Date you first consulted physician: _____

For each notice below, please initial that you have read, understand, and agree to each

Motor Vehicle Accident Patients: Per VA state law, we are **not allowed** to accept assignment from, or bill to, an automobile insurance company and **we do not** wait until settlement is reached for payment. In such cases, you may use your personal health insurance, but they reserve the right to deny payment if another insurance company, even auto insurance company, is responsible for payment. Your health insurance company may also retract payments at any time if another party is found liable for damages. Either way, the full cost of your medical care with us is your responsibility on each date of service. We will (upon your request) provide you with the appropriate records to file your claims.

Initials: _____

Release of Medical Information: Some health insurance and workers compensation companies require process notes and/or re-evaluations to continue treatment or to prove medical necessity for billing purposes. By initialing below, you authorize this center to release all medical records required to these parties to facilitate the continuation of treatment and/or the collection of payments. If a copy of your chart is required for any other reason, you must fill out a separate Release of Medical Records form. There may be charges associated with the copying and distribution of records in this case for which you will be responsible for.

Initials: _____

Consent for Treatment: Your therapist and our Therapy Services Coordinator will educate you on your treatment plan, any precautions, and will work with you to determine mutual goals of physical therapy. Your progress and results will be monitored, and your treatment will be updated as necessary to achieve optimal functional ability. By initialing below, I give full consent for Loudoun Sports Therapy Center to provide evaluation and therapeutic treatment procedures as prescribed by my physical therapist and physician.

Initials: _____



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General Office Policies:

1. Patients are responsible for providing prescriptions and insurance referrals on the first date of treatment if their insurance has such requirements.
2. If any additional referrals or authorizations are needed throughout the course of treatment, they are also your responsibility although we are happy to assist you in this matter.
3. Children are not allowed in the treatment area/on the clinical floor unsupervised. Any child brought to the facility **MUST** stay in the waiting room and **MUST** be supervised by an adult at all times. Children are prohibited in the fitness and treatment area unless they are a patient. **LSTC staff are NOT responsible for supervising children at any time.**

Initials: _____

Notice of Privacy Practices

Our practice is committed to maintaining the privacy of your individual and identifiable information. We are required by law to maintain the confidentiality (of health insurance information that identifies you) from parties other than yourself and your insurance company. We are also required by law to inform you of the parties who may have access to your medical information. This process may include the collection of such information as: your full legal name, home / mailing address, date of birth, social security number, insurance identification numbers, treatment for other related and previous conditions, etc. Please trust that this information will be treated in the safest of manners and will not be shared or disclosed unless as otherwise noted below. This information is never shared with any party outside our facility without your written consent except as noted below and will only be accessed by our staff in order to facilitate your care and or payment for our services.

A copy of our Notice of Privacy Practices is attached to this clip board for your review.

Authorized Individuals:

Please list any individuals with whom Loudoun Sports Therapy Center **may discuss your appointments, billing, treatment, or medical records.**

Name: _____	Relationship: _____	Phone: _____
Name: _____	Relationship: _____	Phone: _____
Name: _____	Relationship: _____	Phone: _____

Restricted Individuals:

You have the right to request a restriction or limitation on the health information we use or disclose about you. Please keep in mind that such a request may alter or affect your treatment outcomes or financial responsibility as related to this condition. Please list below any individual or entity that you want to expressly restrict from accessing your information:

Name: _____	Relationship: _____	Phone: _____
Name: _____	Relationship: _____	Phone: _____
Name: _____	Relationship: _____	Phone: _____

By signing below, you acknowledge that you have received and/or have been offered Loudoun Sports Therapy Centers Notice of Privacy Practices. A copy is available on our website or by requesting a printed copy from our staff at any time.

Patient/Guardian Signature

Patient Name (Printed)

Date



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Financial Policy & Card on File Agreement

At Loudoun Sports Therapy Center, our patient care is our primary concern. In order to avoid any miscommunication, we would like you to review the following financial policy. We encourage you to come to us, without hesitation, regarding any concerns that you may have. Please read each part of this agreement.

1. As a courtesy to you, we will verify your insurance benefits and eligibility prior to your evaluation and inform you of the benefits information at your initial visit. It is your responsibility to verify your own insurance benefits. We assume no responsibility for errors made by your insurance carrier and assuring accurate payment is ultimately your responsibility.
2. If your insurance company requests further information **from you**, it is **your responsibility** to complete the request immediately. Failure to complete their request may result in denial of the claim and you will be responsible for the full billed amount for all rendered services.
3. If your insurance denies payment for services because you are beyond your yearly maximum number of visits, or for not meeting medical necessity, you will be fully responsible for the full billed amount for all rendered services.
4. **If your address, phone number, card on file, or insurance information changes during your care, you must immediately inform Loudoun Sports Therapy Center staff. Failure to inform us of such changes will result in you being responsible for the full billed amount of any denied claims and late fees resulting from such changes.**
5. **Payment is expected at the time of service.** Payment will be processed per the Card On File Agreement if not made by other means at the time of service. Failure to ensure successful payment is made may result in late fees for which you are responsible.
6. **With the exception of Medicare, Medicaid and Tricare, we do not accept assignment from secondary insurances.**
7. There is a \$25.00-\$50.00 charge for returned checks, depending on bank fees.
8. If your account has an unpaid balance over 30 days, it will be considered in an internal collection status and a \$50.00 late fee will be applied.
9. If your account remains unpaid for an additional 30 days, 60 days in total, we will apply an additional \$75.00 late fee to your account.
10. If your account remains unpaid, either in part or in full, for 90 days or more, you will receive a subpoena demanding your appearance in small claims court **and/or** we will send your account to a collections agency. There is an additional \$125.00 fee for these costs. This fee will be applied to your account and will be your responsibility.

Card on File Authorization

To help make billing simple and efficient, Loudoun Sports Therapy Center requires a valid debit or credit card on file for all patients with a financial responsibility. Your card may be charged for:

- Financial responsibility due at the time of service.
- Balances remaining after your insurance has processed your claims.
- Missed visit fees in accordance with our Cancellation Policy.
- Other balances you authorize or are responsible for under our financial policy.

If your insurance leaves a balance after processing your claims, we will send you an itemized statement by email. Unless you contact us within 5 business days, the balance may be charged to the card on file. You agree to:

- Maintain a valid card on file and provide updated payment information if your card expires or changes.
- Contact our Billing Department promptly if you believe a charge is incorrect.
- Work directly with Loudoun Sports Therapy Center to resolve billing concerns before disputing a charge with your card issuer.

Your payment information is securely stored using PCI-compliant payment processing. Our staff cannot view your full card number once it has been entered into our system.

By signing below, you acknowledge that you have read and understand Loudoun Sports Therapy Centers financial policy and you agree to the terms there above. You understand that medical insurance claims will be filed on your behalf and by signing below, you agree to such billing. You authorize your insurance company to remit payment for therapy services to Loudoun Sports Therapy Center at the address listed on the claim. You also authorize the release to your insurance company any medical information necessary to process your claim for payment. You understand that if your insurance company denies payment for any reason, you are responsible for services rendered at Loudoun Sports Therapy Center. You accept all terms of this agreement. You authorize Loudoun Sports Therapy Center to securely store my payment information and charge your card as outlined above.

Patient/Guardian Signature

Patient Name (Printed)

Date

Missed Visit Policy

At Loudoun Sports Therapy Center, our goal is to help all patients reach a fully recovered state. Your physical therapist will provide you with your plan for care during the evaluation appointment and will inform you of the required number of visits to help you achieve your goals. Patients who attend all of their physical therapy visits are 93% more likely to fully recover from an injury whereas those that miss even one visit have a lower potential for recovery. This policy ensures that all patients have the opportunity to receive the care they need.

Please read our policy and sign at the bottom indicating you understand our expectations and our policy

1. As experts, we know that **you will not reach full recovery if you do not attend your appointments**. To help ensure you have the best chance at recovery, we will work with you to schedule out all of your appointments after your evaluation today and in order to have the best chance at recovery, you will need to attend each visit.
2. **Please note:** Our goal is to begin your treatment sessions on schedule. For all appointments after your evaluation, we expect that you will arrive at least 5 minutes prior to your appointment time, dressed for your session, and ready to begin at on time. This will allow our front office to handle their responsibilities and our specialists to provide the care you need and deserve.
3. If you're late for your appointment, you're missing the time that we have specifically scheduled for your care and we cannot guarantee that we will be able to provide you with your full treatment as we have reserved the appointment time following yours for someone else.
4. **If you're running late**, we need you to call us immediately so we can prepare for your late arrival and consult with your clinician. If you are more than 15 minutes late, your session may need to be rescheduled and, we reserve the right to charge our missed visit fee for the lost session. Chronically late patients will be asked to change their appointment times.
5. While we understand that illness can strike at any time, we still expect that you will work to provide at least **a days notice, within business hours**, if you cannot attend a scheduled appointment.
6. Providing care to all patients is extremely important to us and late notice of changes or cancellations will keep someone else from getting the care they need and deserve. **If you need to cancel or change a scheduled appointment, for any reason, we require a days notice, within business hours, so we have enough time to help another patient who needs to get in for the care they need and deserve.**
7. When you call to cancel an appointment, have your schedule ready as we will reschedule you right away.
8. **We reserve the right to charge a missed visit fee of \$85.00 if you do not provide proper notice of your appointment change or cancellation, and we will comply with payer policy in carrying it out.**
9. **To avoid our missed visit fee, we need you to call our office during business hours - at least a day in advance for any illness, appointment changes or cancellations.**
10. Patients who have multiple same-day cancellations or no-shows, will be removed from the active schedule, and will be placed on day-to-day status to avoid future missed visit charges.
11. If you're worker's comp, we are required to notify your claims adjuster if you cancel or no-show for an appointment.

We look forward to working with you to meet your physical therapy goals. **To avoid any issues with our policy, we only need the required notice, so we have enough time to help all patients get in for the care they need and deserve.**

By signing below, I acknowledge that I have read this policy and I am indicating that I understand and will adhere to this policy.

Patient/Guardian Signature

Patient Name (Printed)

Date