Date: _____

DIRIGO
PHYSICAL THERAPY & PERFORMANCE

PATIENT INFORMATION

Last Name _____ First Name _____ MI____

Date of Birth _____ Sex: _____ Guardian's Name (if applicable) _____

SSN ___-_____-_____ Phone #: _____Cell Phone #: _____

E-Mail_____

Appointment Reminder (Optional): ☐ Text (please provide cell phone carrier) _____ ☐ Email

Address: _____

City _____ State _____ Zip_____

What is your favorite music genre or streaming channel? _____

How did you hear about Dirigo Physical Therapy & Performance? _____

PHYSICIAN INFORMATION

Primary Care Physician_____ Location_____

Referring Physician (if different)_____ Location_____

PRIMARY INSURANCE

(Without this information we cannot bill your insurance correctly)

Insurance Carrier_____

Member ID #_____ Group #_____

Subscriber Name_____ Subscriber Date of Birth_____

Subscriber's SSN ___-___-_____ Relationship to Patient: _____

SECONDARY INSURANCE (if applicable)

Insurance Carrier_____

Member ID #_____Group #_____

Subscriber Name_____ Subscriber Date of Birth _____

Subscriber's SSN ___-___-_____ Relationship to Patient: _____

I AM RESPONSIBLE TO KNOW MY INSURANCE BENEFIT!

Please Initial Here_____

Date: _____

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PHYSICAL THERAPY & PERFORMANCE

AUTO INSURANCE (if necessary)

Name of insured _____ Claim #_____

Auto Insurance Company Name _____

Address _____

City _____ State _____ Zip _____

Adjustor's Name _____ Phone #_____

WORKER'S COMPENSATION (if necessary)

Employer's Name (at time of injury) _____

Address_____

City_____State_____Zip_____

Occupation_____

W/C Insurance Company Name _____Claim # _____

Address _____

City _____ State _____ Zip _____

Adjustor's Name _____Phone #_____

ATTORNEY INFORMATION (if necessary)

Name _____ Phone #_____

Date: _____

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PHYSICAL THERAPY & PERFORMANCE

HISTORY OF PRESENT ILLNESS

For what condition or symptoms are you being seen for at this time? _____

_____

When did this condition begin? _____

Have you had PT in THIS Calendar year? Y or N How many visits? _____

What treatments have you already received? _____

Please list or supply us with a list of all medications that you are currently taking:_____

_____

_____

Please list all allergies: _____

PAST MEDICAL HISTORY

Please indicate all past surgeries:_____

Do you have a history of falls?_____ If *Yes*, when was your last fall?_____

Please indicate whether you have had the following conditions:

Cancer		Bleeding/Clotting Disorder	
Heart Disease		Stroke/TIA	
Arthritis/Gout		Diabetes	
High Blood Pressure		Hernia	
Respiratory Disease		Thyroid Disorder	
Asthma		Kidney or Bladder Problem	
Pneumonia/Emphysema		Vascular Disease	
HIV, Hepatitis, or other infectious disease		Are you pregnant?	
Do you have any surgical implant/pacemaker?		Other:	

Date: _____

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PHYSICAL THERAPY & PERFORMANCE

AUTHORIZATION TO PAY DIRIGO PHYSICAL THERAPY & PERFORMANCE

Assignment of Benefits

I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO DIRIGO PHYSICAL THERAPY AND PERFORMANCE AND I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES. I ALSO AUTHORIZE DIRIGO PHYSICAL THERAPY AND PERFORMANCE TO RELEASE ANY INFORMATION TO PROCESS THIS CLAIM.

_____

Patient Signature Date

_____

Parent of Guardian Signature (if under 18) Date

CONSENT TO TREATMENT

I, THE UNDERSIGNED, VOLUNTARILY AUTHORIZE DIRIGO PHYSICAL THERAPY AND PERFORMANCE TO ADMINISTER PHYSICAL THERAPY THAT IS NECESSARY AS APPROPRIATE IN THE OPINION OF THE REFERRING PHYSICIAN AND/OR THE ALLIED HEALTH PERSONAL. PHYSICAL THERAPY IS NOT AN EXACT SCIENCE AND NO GUARANTEE HAS BEEN MADE TO THE RESULT OF ANY TREAMENT ADMINISTERED. BY SIGNING THIS, I ACKNOWLEDGE RECEIPT OF THE NOTICE OF INFORMATION PRACTICES OF DIRIGO PHYSICAL THERAPY AND PERFORMANCE. I ALSO ACKNOWLEDGE I HAVE READ THE CLINIC POLICES POSTED AT THE FRONT DESK

_____

Patient Signature Date

_____

Parent of Guardian Signature (if under 18) Date

Date: _____

DIRIGO
PHYSICAL THERAPY & PERFORMANCE

Physical Therapy Attendance Policy
(Please read thoroughly)

Dirigo Physical Therapy & Performance strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient with a specific therapist in order to minimize your waiting and assure continuity of your treatment. Your consistent attendance of the planned treatment regimen is paramount to your full recovery.

While we are sensitive to the fact that an emergency may occur in a rare instance, cancellations, especially last-minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of the other patients. Additionally, no-shows display a complete lack of respect for your therapist and fellow patients. We must ask for your full cooperation with the following policy:

- If you are more than 30 minutes late for your appointment and fail to notify us, treatment may be cancelled, and a fee charged for missing the appointment.
- A scheduled appointment MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE, or a fee will be charged for that appointment.
- Failure to show up for an appointment ("NO SHOW") without notifying us will result in a fee being charged for that appointment. ***Furthermore, 2 consecutive no-shows will result in the cancellation of all remaining scheduled appointments.***
- At week's end, ALL PATIENTS, regardless of insurance/third party payor, will be charged a $50 CANCELLATION FEE for each late, late-cancelled, or no-show appointment. ***THE PATIENT IS RESPONSIBLE FOR THE FEE, NOT THE INSURANCE/THIRD PARTY PAYOR.***
- No cancellation fee will be charged if the missed appointment is made up within the same week it was scheduled on a day that you do not have another appointment scheduled.
- All cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payor.
- Repeated failure to comply with this ATTENDANCE POLICY will result in your name being placed on a "Schedule Based on Availability" list. This will require you to call for an open appointment on each day you would like to receive therapy. We will do everything possible to accommodate you, as space on the schedule permits.

We believe that this policy is necessary for the benefit of all our patients, so that we may continue to provide high quality treatment and service to everyone. All of the staff at **Dirigo Physical Therapy & Performance** appreciates your anticipated adherence and cooperation with this policy. We wish you the best of luck with your treatment. We are here to help you attain all your goals and optimize your return to your pre-injury activities.

_____ ____/____/____
Patient Acknowledgement Signature Date

Date: _____

DIRIGO
PHYSICAL THERAPY & PERFORMANCE

Health Insurance Portability and Accountability Act (HIPAA) Practice Notice

Federal law requires Dirigo Physical Therapy and Performance and its health care providers and staff to maintain the privacy of Individually identifiable health information and to provide you with notice of their legal duties and privacy practices with respect to such information. Dirigo Physical Therapy and Performance and its related health care providers and staff must abide by the terms and conditions of this Privacy Notice.

The health care providers at Dirigo Physical Therapy and Performance are required to seek your written acknowledgment that you have received this Notice. By furnishing written acknowledgment of receipt, you do NOT indicate your agreement or consent to the uses and disclosures of information described in this Notice. The acknowledgment indicates only that you have received this Notice. We make every effort to comply completely with these HIPAA privacy regulations. Please provide us with the following information so that you are not inconvenienced when you need to have a family member call us regarding your healthcare or account information.

Check Yes or No

YES	NO	
☐	☐	**I give staff and medical providers acting on behalf of Dirigo Physical Therapy and Performance permission to leave messages on my answering machine or voice mail regarding appointment times, treatment and account/insurance information.**
☐	☐	**I give staff and medical providers acting on behalf of Dirigo Physical Therapy and Performance permission to discuss appointment times, treatment and account/insurance information with the following persons.**

Name of Designee _____ Relationship to Patient _____

Phone #: _____ Cell Phone #: _____

Name of Designee _____ Relationship to Patient _____

Phone #: _____ Cell Phone #: _____

I acknowledge that I have been provided with a copy of the privacy notice for Dirigo Physical Therapy and Performance privacy notice and have been given an opportunity to read and ask questions about the notice.

I have read and understand the above terms and conditions of the Authorization and agree to its contents.

_____
Signature Date

_____
Witness Date

Date: _____

DIRIGO
PHYSICAL THERAPY & PERFORMANCE

NOTICE OF INFORMATION PRACTICES

UNDERSTANDING YOUR HEALTH INFORMATION RIGHTS:

Although your health record is the physical property of the healthcare provider, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information (45CFR164,522)
- Obtain a paper copy of the notice of information upon request -Inspect and obtain a copy of your health record (d5 CFR164,524)
- Request and amend your health record (45 CFR 164,528)
- Obtain an accounting of disclosures of your health information (45 CFR 164,528)
- Request communications of your health information by alternative means or alternative locations
- Revoke your authorization to use or disclose health information except to the extent that actions have already been taken

OUR RESPONSIBILITY:
We are required to:

- Maintain privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to your information
- Abide by the terms of this notice
- Accommodate reasonable requests you may have to communicate health information by alternative means or locations. We reserve the right to change our practices and to make the changes effective for all protected health care information we maintain. If our information practices change we will notify you the next time you come in to our office for treatment.

If you have any questions and would like additional information, you may contact Health and Human Services. If you believe your privacy rights have been violated, you can file a complaint with the secretary of Health and Human Services. We will not retaliate if you file a complaint.

Examples of Disclosures for treatment, Payment and Health Operations

We will use and disclose your health information for treatment. For example: information obtained by us will be recorded in your record and used to determine the course of treatment that should work best for you. Members of your healthcare team will then record the actions they took and their observations. In that way your physicians and other providers will know how you are responding to treatment. Copies of these records as well as other reports will be provided to other providers participating in your care to assist them in treating you if you are referred to them for consultation.

We will use and disclose your health information for payment. For example, a bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedure sand supplies used. Additionally, we may be required to forward additional information to substantiate the medical necessity of the care delivered and that the care for which the claim was submitted was actually delivered. Further, we may disclose health information to the extent authorized and to the extent necessary to comply with worker's compensation or other similar programs established by law.

We will use and disclose your health information for regular health operations. For example, members of our staff may use the information in your health record to phone you regarding confirmation of appointments or to notify patient of missed appointments. Logistics may dictate the portions of treatments are conducted in an open gym atmosphere where disclosures may be overheard. Every reasonable precaution is taken to limit these events.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include services by laboratories, copy services, and transcription services. When these services are contracted, we may disclose your health information to our business associate so that they can perform their job we've asked them to do. However, to protect your health information we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information or assist in the notifying a family member, personal representative or another person responsible for your care, of your location, and general condition.

Family Communication: After careful judgment, we may disclose to a family member or other person you designate health information relevant in that person's involvement in your care or payment related to your care, of your location and general condition.

Funeral Directors & Organ Procurement Organizations: We may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant. Public Health As required by law, we may disclose health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law Enforcement and Correctional Institution: We may disclose health information for law enforcement purposes required by law should you be an inmate of a correctional institution; we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.
Federal Law makes provision for your health information to be released to an appropriate health oversight agency, public health authority, provided that we or our business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.
EFFECTIVE DATE JUNE 1, 2018

Date: _____

DIRIGO
PHYSICAL THERAPY & PERFORMANCE

Authorization for Credit Card Use

All information will remain confidential

Dirigo Physical Therapy and Performance will keep an active credit card on file. This card can be used to pay for any account balances as they occur, such as co-pays and co-insurances. Any unpaid patient account balances will be automatically charged to the card on file if the account is 90 days past due. I further agree, that in the event that I do not pay amounts owed in full within 30 days of them becoming due, I will pay an additional service charge of 18% per annum. If it is found necessary to turn my account over to a collection agency or an attorney due to non-payment, I understand that I will be responsible for reasonable attorney fees and court costs associated with the collection of my account.

(Select **One**)

- ☐ I authorize Dirigo Physical Therapy and Performance to charge my card for all account expenses as the arise.

- ☐ I authorize Dirigo Physical Therapy and Performance to charge my credit card only for past due account balances.

Name on Card: _____

Billing Address: _____

_____

_____

Cardholder – Please Sign and Date

Signature: _____

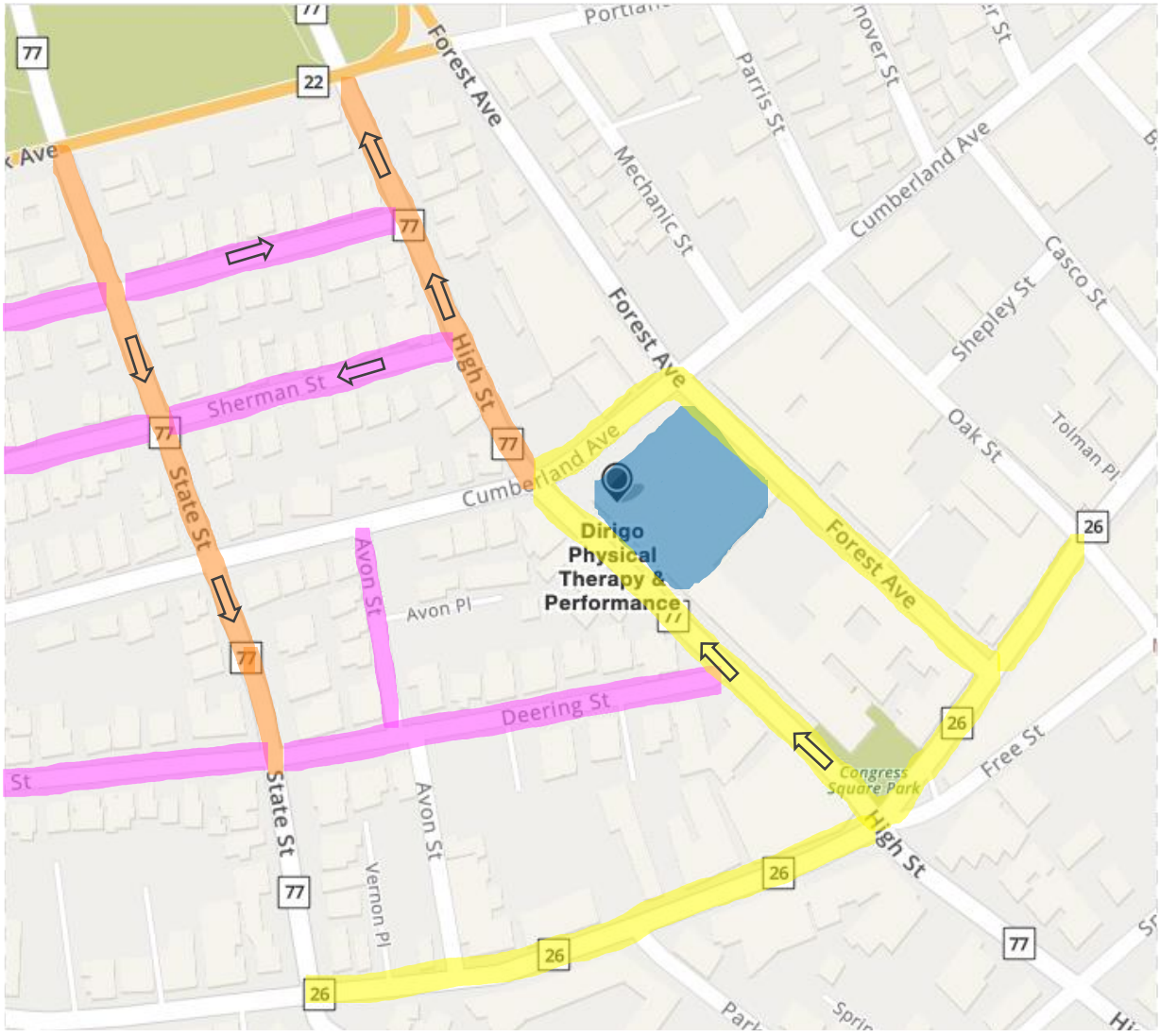
Date: _____

Print Name: _____

Date: _____

DIRIGO
PHYSICAL THERAPY & PERFORMANCE

Patient Parking Map



2 Hour Metered Parking =

1 Hour Free Parking =

* Street Maintenance Rules (Oct 1st-May 31st):
no parking on odd side of the street on the 1st & 3rd Thursday of the month from 10AM-2PM
no parking on even side of the street on the 2nd & 4th Thursday of the month from 10AM-2PM
(If there is a 5th THURSDAY in a month there is no enforcement)

Free All-Day Parking =

Hourly Paid Parking Garage =

185 High Street • Portland, Maine 04101 • (207) 536-4968 • Fax: (207) 213-4116 • www.DirigoPTP.com