HARTER
Physical Therapy

Welcome to the Harter Physical Therapy family!

At Harter Physical Therapy, we care about the difficulties you are experiencing. We care about your pain. We care about your recovery. We care about you.

We want to commend you for taking the first step towards improving your health and wellness.

You are in good hands.

At Harter Physical Therapy, we are driven by clinical excellence. Every clinician you see is a licensed Doctor of Physical Therapy. In addition to being a doctor, your clinician has completed rigorous training in Orthopedics and Manual Therapy to truly become an expert in the field. At Harter Physical Therapy, our outcomes are consistently in the top 1% in the nation.*

We understand there are many choices when prioritizing your health and wellness and want to say thank you for choosing Harter Physical Therapy. Our goal is simple; to provide to you the highest level of care in our industry. We are excited for you to experience the clinic and atmosphere that we have created, and hope you have a very positive experience at Harter Physical Therapy.

Sincerely,

Drs. Amanda and Gabe Harter

(*Outcomes are tracked by WebPT Outcomes)

Goddard Location:
19931 W. Kellogg Dr. STE A, Goddard, KS 67052
Ph: (316) 550-6132 Fax: (316) 550-6215

Cheney Location:
126 N. Main St. Cheney, KS 67025
Ph: (316) 550-6132 Fax: (316) 550-6215

Informed Consent and Release of Liability

1. **CONSENT TO TREATMENT**: I consent to rehabilitation and related services at Harter Physical Therapy, LLC. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. I understand I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 24 hours, I agree to contact my physical therapist. Further that such Services and any equipment I may use as part of these Services have inherent risks, dangers, and hazards and such exists in my use of any equipment and my participation in these activities; and my participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to, bodily injury, disease, strains, fractures, partial and/or total paralysis, death or other ailments that, could cause serious disability. By my participation in these activities and for use of equipment, I hereby assume all risks and dangers and all responsibility for any losses and/or damages. I understand that my physical therapist at Harter Physical Therapy, LLC, cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will share with me his/her opinions regarding potential results of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

2. **TREATMENT OF MINORS:** I, as parent/guardian of a minor receiving treatment here under, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

3. **LIABILITY**: I know and agree that Harter Physical Therapy, LLC is not responsible for loss or damage to personal valuables.

4. **WAIVER AND RELEASE:** I hereby release, discharge and acquit Harter Physical Therapy, LLC, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

5. **AUTHORIZATION OF PAYMENT:** I hereby assign all benefits directly to Harter Physical Therapy, LLC and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

6. **ACKNOWLEDGMENT OF RECEIVAL OF NOTICE OF PRIVACY PRACTICES POLICY:** I have received, understand, and agree to all information included and described in the Harter Physical Therapy, LLC Notice of Privacy Practices.

By signing below, I certify that I have read and understand the above document and agree and consent to all terms.

Patient/Guardian Signature: _____ Date: _____

Printed Patient Name: _____

If Guardian, Relationship to Patient: _____

Financial Policy

Thank you for choosing Harter Physical Therapy, LLC as your Physical Therapy provider. We are committed to providing the best possible care for you. In order to achieve this goal, we need your assistance in understanding our financial policy. Please understand that payment of your bills is considered part of your treatment. The following is a statement of our Financial Policy. Please read each section and sign prior to your treatment.

Non-Covered Expenses

You are directly responsible for payment of medical supplies. You may be responsible for payment of charges denied due to the insurance company's arbitrary determination of usual and customary rates. There may also be charges that your insurance does not cover due to limitations of your policy, or what they consider reasonable and necessary. It is your responsibility to know what the policy limitations are. Our goal is to improve your condition successfully based on what the doctor deems reasonable and necessary treatment, and not on what your policy limitations are. Therefore, unless you alert us prior to treatment, you will be financially responsible for non-covered expenses.

Secondary Insurance

If you have a co-pay with your primary insurance, and you have a secondary insurance, we will as a courtesy to you submit this to your secondary insurance a maximum of two times. If no payment is received or your secondary insurance does not respond, you will be billed and expected to pay the balance, at which time you will be given a "paid" receipt that you will then be able to submit to your secondary insurance for reimbursement.

Missed Appointment Policy

Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival of greater than 15 minutes may result in a shortened treatment or cancellation. It is our policy to reschedule any canceled appointments for the same week at the time of your call. **There is a $50 charge for a cancellation without a 24 hour notice.** Attending your scheduled appointments is crucial to successful treatment and recovery from your injury.

Balance Accrual Policy

If your account has accrued a balance of over $100.00, we will require some form of payment prior to your next therapy session. If you are having difficulty with payments, please speak with us before canceling appointments. **Unpaid balances over 60 days will be charged a $100.00 late fee.**

Returned Checks Policy

Returned checks will be subject to **$45.00** collection charge in addition to the original check amount.

Medicare Patients Only

I request that authorized Medicare benefits made to me or on my behalf be paid to the practitioner named above. I authorize any holder of medical information about me to release to the Health Care Financing administration and its agents any information needed to determine benefits or the benefits payable for related services. I certify that the information given by me for payment under Title XVIII of the Social Security Act is correct. I have read this information and understand its content.

I have read, understand, and agree to this Financial Policy. I am also aware of, and understand my policy benefits for treatment.

Patient/Guardian Signature: _____ Date _____

Payment Policy

Harter Physical Therapy is in network with most insurances. This means we have a contractual agreement to provide physical therapy services and submit claims in accordance with your carrier's insurance policy. As a courtesy to you, we have verified your insurance benefits to provide information on the financial implications of your policy, including the approximate cost per visit of your plan of care. At Harter Physical Therapy, we understand and respect that every patient's financial situation is unique. If you have concerns about the financial impact of your physical therapy plan of care, please verbalize this to your Doctor of Physical Therapy. We will do our best to create a plan of care that maximizes the value of your treatment with us.

Please keep in mind that the payment made at the time of service may be a partial payment for your overall physical therapy costs. If you are paying the estimated deductible or coinsurance amount per date of service, you may have a bill at the conclusion of therapy. Please understand that our payment estimates are only as accurate as the information provided to us by your insurance company. At times, insurance companies can take 60-90 days from the date of service to provide claim coverage information to us. The cost fluctuation per visit may be at the discretion of your insurance provider. If you have an amount owed at the completion of your plan of care with Harter Physical Therapy, that amount will be due upon receiving the statement.

All Copays, Coinsurance, and Deductible payments are due at time of each appointment.

Copays

Most insurance providers classify physical therapy services under the "Specialist" designation. **The copay amount will be due at time of service each visit until otherwise described in your insurance policy.**

Coinsurance

Coinsurance is typically a percentage of shared cost between you and your insurance provider once your deductible is met. **If you have a coinsurance obligation for physical therapy, your payment per visit will be calculated by the coinsurance percentage multiplied by 100**. For instance, if you have a 20% coinsurance, you will have a $20 payment at time of service unless otherwise specified in your insurance policy.

Deductible

Deductible is the amount your insurance provider will have you pay out of pocket before cost sharing, coinsurance, or additional insurance coverage takes place. **Your deductible payment will be $150 at the initial evaluation and $85 for each visit.** These amounts will be due at time of service.

Payment Options – Credit Card on File

For your security and protection, Harter Physical Therapy stores your encrypted and tokenized credit card data in an off-site, secure vault that exceeds all HIPAA and PCI Data Security Standards.

I authorize Harter Physical Therapy to automatically debit the card on file for any patient responsibility, including standard co-pays, remaining balance, payment plans and no-show fees.

I understand that I can update my card information on file at any time by contacting Harter Physical Therapy directly. I understand it is my responsibility to notify Harter Physical Therapy of any updates or changes to the credit card on file associated with this agreement as soon as possible.

By signing below, you acknowledge you have read, understand, and agree to Harter Physical Therapy's Payment Policy.

Signature: _____ Date: _____

PATIENT INFORMATION CONSENT FORM

Disclosure Authorization – For Release of Protected Health Information (PHI)

I have read and fully understand Harter Physical Therapy, LLC's Notice of Privacy Practices. A copy of the Notice of Privacy Practices is available in the front waiting area or a hard copy may be obtained upon request. I understand that Harter Physical Therapy, LLC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that that Harter Physical Therapy, LLC's Physical Therapist will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions. I give my permission to Harter Physical Therapy, LLC to release information, verbal and written, from my medical record to my physician, insurance company, rehab nurse, case manager, attorney, employer, school, related health-care provider, or other assignees as it relates to my treatment. I further authorize Harter Physical Therapy, LLC to obtain medical records from my physician or other medical professionals as it relates to my treatment.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Harter Physical Therapy, LLC's Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Signature:_____ Date: _____

I give permission to Harter Physical Therapy, LLC to disclose and discuss any information related to my medical condition(s) including but not limited to date and time of appointments, account information, insurance information, and/or medical records with the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

How Did You Hear About Us?

Please include a brief description or name next to how you heard about us.

☐ Friend/Family Member: _____ ☐ Physician: _____

☐ Other Healthcare Professional: _____ ☐ Google Ad/Search _____

☐ Newsletter: What Month/Topic? _____ ☐ Website: _____

☐ Social Media: ☐ Facebook ☐ Instagram ☐ Twitter ☐ Linkedin ☐ YouTube

☐ Familiar with our clinic location/saw our signage ☐ Other _____

Thank you for your patience while completing the intake paperwork. The length of our paperwork is due to insurance companies requiring us to gather specific data on each patient we see, as well as us gathering information to assist your Doctor of Physical Therapy to perform a concise evaluation of your condition. We understand paperwork can be tedious, and have attempted to make this process as efficient as possible. If you are in the waiting room filling these documents out, please help yourself to coffee or water. We allow our patients to request clinic appropriate music or songs in the waiting room so please ask if a type of music comes to mind!

HARTER Physical Therapy

Patient Intake Form

The information requested in this section is required for our medical records and by your insurance company to file proper claims. We also want to know what your preferred way of being contacted is so we can communicate with you in the most efficient way.

First Name: _____ Last Name: _____ Middle Initial: ____

Date of Birth: _____ SSN: _____ – ___ – _____ Gender: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Phone number: _____ Email: _____

Is it OK to leave messages at this number? ☐ Yes ☐ No

Is it OK to send emails to the above email address? ☐ Yes ☐ No

At Harter Physical Therapy, we offer appointment reminders that are complementary and completed approximately 24 hours before your physical therapy appointment with us. Which appointment reminder would be most convenient for you?

☐ Voice Call ☐ Text Message ☐ Email ☐ No Reminders, please.

Emergency Contact Information

Name of person you wish us to contact in case of an emergency: _____

Relationship to you: _____ Phone number of emergency contact person: _____

Employment Information

Employer: _____ Job Description: _____

Were you injured on the job? ☐ Yes ☐ No

Primary Care Physician Information

Name of Primary Care Physician: _____ Date of last examination: _____

Name of Referring Physician/Provider (If different than your primary care physician): _____

Insurance Information

Primary Insurance: _____ Member ID number: _____

Insured Name: _____ Insured DOB: _____ Group Number: _____

Secondary Insurance: _____ Member ID number: _____

Insured Name: _____ Insured DOB: _____ Group Number: _____

Information About Your Past Medical History

In this section, we ask for information to help us understand more about your overall health. This will help us get a better idea of the complexity and nature of your condition and will assist your Doctor of Physical Therapy in determining the healing potential of the affected body part and the overall plan of care timeline.

Last name: _____ DOB: _____ Height: _____ Weight: _____ lbs

How would you rate your current health? ☐ Good ☐ Fair ☐ Poor

In the past year have you experienced a fall? ☐ Yes ☐ No

If Yes: Did the fall cause an injury? ☐ Yes ☐ No What was injured? _____

Do you currently use tobacco products? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No

Do you have a history of smoking? ☐ Yes ☐ No

If Yes, for how long and when did you quit? _____

Are you pregnant? ☐ Yes ☐ No ☐ Not Applicable

Please review the below list and place a check box next to any medical conditions that you have experienced or have been diagnosed with:

- ☐ Dizziness
- ☐ Double Vision
- ☐ Difficulty Speaking
- ☐ Difficulty Swallowing
- ☐ Drop Attack/Syncope
- ☐ Difficulty Walking
- ☐ Nausea
- ☐ Nystagmus
- ☐ Numbness
- ☐ Headache/Migraine
- ☐ Changes in Bowel/Bladder Function
- ☐ Unexplained Weakness
- ☐ Abnormal weight loss/gain
- ☐ Night Pain
- ☐ Night Sweats
- ☐ History of Cancer
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Low Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Stroke/CVA
- ☐ Pacemaker
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Asthma
- ☐ Emphysema
- ☐ COPD
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Allergies: _____
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Osteoarthritis
- ☐ Rheumatoid Arhtritis
- ☐ Fibromyalgia
- ☐ Complex Regional Pain Syndrome
- ☐ Anxiety
- ☐ Depression
- ☐ Parkinson's Disease
- ☐ Amyotrophic Lateral Sclerosis (ALS)
- ☐ Multiple Sclerosis (MS)
- ☐ Ankylosing Spondylitis
- ☐ Bleeding disorders
- ☐ MRSA

Relevant Prior Surgeries: _____

_____

Other information in your past medical history you would like us to know: _____

_____

Information about your Pathology/Condition

In this section, we ask for information to help us understand more about your pain or dysfunction and how it is affecting your life. This information will help your Doctor of Physical Therapy diagnose your pathology, develop a treatment plan, and create goals specific to you and your life.

What area is injured or dysfunctional/What would you like treated? _____

How did this injury occur? _____

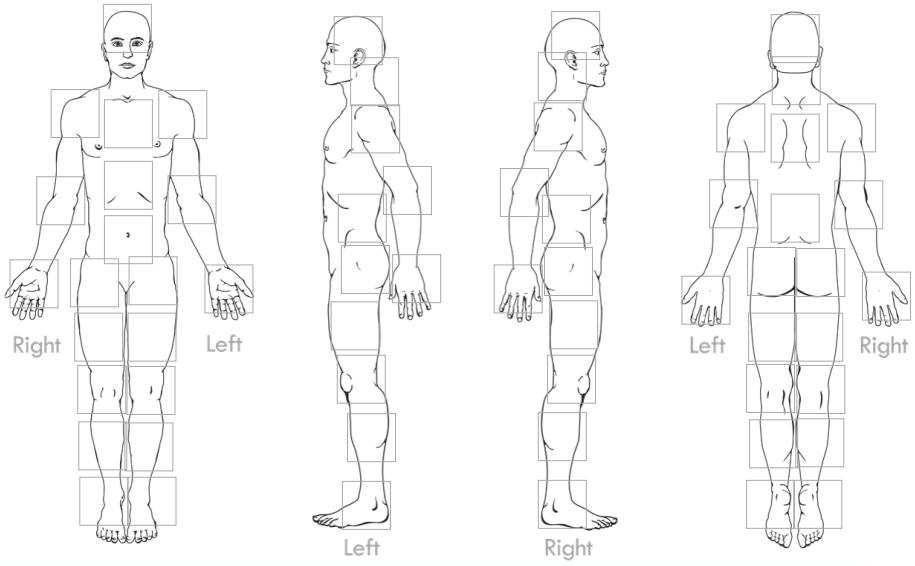
When did this injury happen? _____

Did this injury occur during a period of increased stress in your life? ☐ Yes ☐ No

Did you have surgery? ☐ Yes ☐ No If Yes, what was the date of your surgery? _____

What type of surgery did you have? _____

Please click on the body area below to indicate the region of your pain/condition



Please rate your pain at **worst** on the following scale. 0 1 2 3 4 5 6 7 8 9 10
Please rate your **current pain** on the following scale. 0 1 2 3 4 5 6 7 8 9 10
Please rate your pain at **best** on the following scale. 0 1 2 3 4 5 6 7 8 9 10

How would you describe your pain? ☐ Dull Ache ☐ Sharp ☐ Burning ☐ Throbbing

☐ Pins and Needles ☐ Radiating ☐ Other: _____

Do you experience any numbness or tingling? ☐ Yes ☐ No If Yes, where? _____

What activities do you have difficulty performing due to your current condition? _____

_____

What makes your pain/condition better? _____

What makes your pain/condition worse? _____

What personal goals do you hope to achieve with physical therapy? _____

_____

Medication List

	Medication Name	Dosage	Frequency/day	Reason Taking
	Example: Lotrel	*10mg*	*1 time per day*	*High Blood Pressure*
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				