Keystone health therapy

21 N Fisher Park Way,
Eagle ID 83616
P: 208.514.0670
F: 208.549.7880
Keystone.health

Patient Name

Full Name: _____/_____/_____/_____
(Legal Last Name) (Legal First Name) (Middle Initial) (Preferred First Name)

Date of Birth:_____/_____/_____ Age: _____ Sex/Gender: _____

Address: _____/ _____/ _____/ _____
(Street/PO Box) (City) (State) (Zip Code)

Phone #: (____) _____ (____) _____ (____) _____ Email: _____
(Home) (Work) (Cell/Other)

Occupation/Employer:_____ ❑ Full-Time ❑ Part-Time ❑ Student ❑ Retired ❑ Unemployed

Are you: ❑ Single ❑ Married ❑ Partnered ❑ Divorced ❑ Widowed Partner's Name: _____

Primary Insurance

Insurance Carrier: _____ Plan Name: _____

ID/Subscriber #: _____ Group #:_____

Primary on Policy? ❑ Yes ❑ No, answer following for Primary Insured:

Legal Name: _____ DOB: _____/_____/_____

Insured's ID #:_____ Patient's Relationship to Insured: _____

Secondary Insurance

Insurance Carrier:_____ Plan Name: _____

ID/Subscriber #: _____ Group #: _____

Primary on Policy? ❑ Yes ❑ No, answer following for Primary Insured:

Legal Name: _____ DOB:_____/_____/_____

Insured's ID #: _____ Patient's Relationship to Insured: _____

By signing below, I verify that the above information is correct and true to the best of my knowledge. I authorize Keystone Therapy to treat me. I authorize all insurance payments to be made directly to Keystone Therapy. I consent to the release of all information the insurance company may request for filing their claims. I understand Keystone Therapy will bill my insurance as a courtesy to me, but many insurance companies do not cover all charges, and that I will be responsible for and will pay for any charges not covered by my health care plan. I have received and reviewed the handout called *Privacy Practices Notice*. I understand that I can ask for further information if needed.

Patient or Responsible Party Signature: _____ Date: _____

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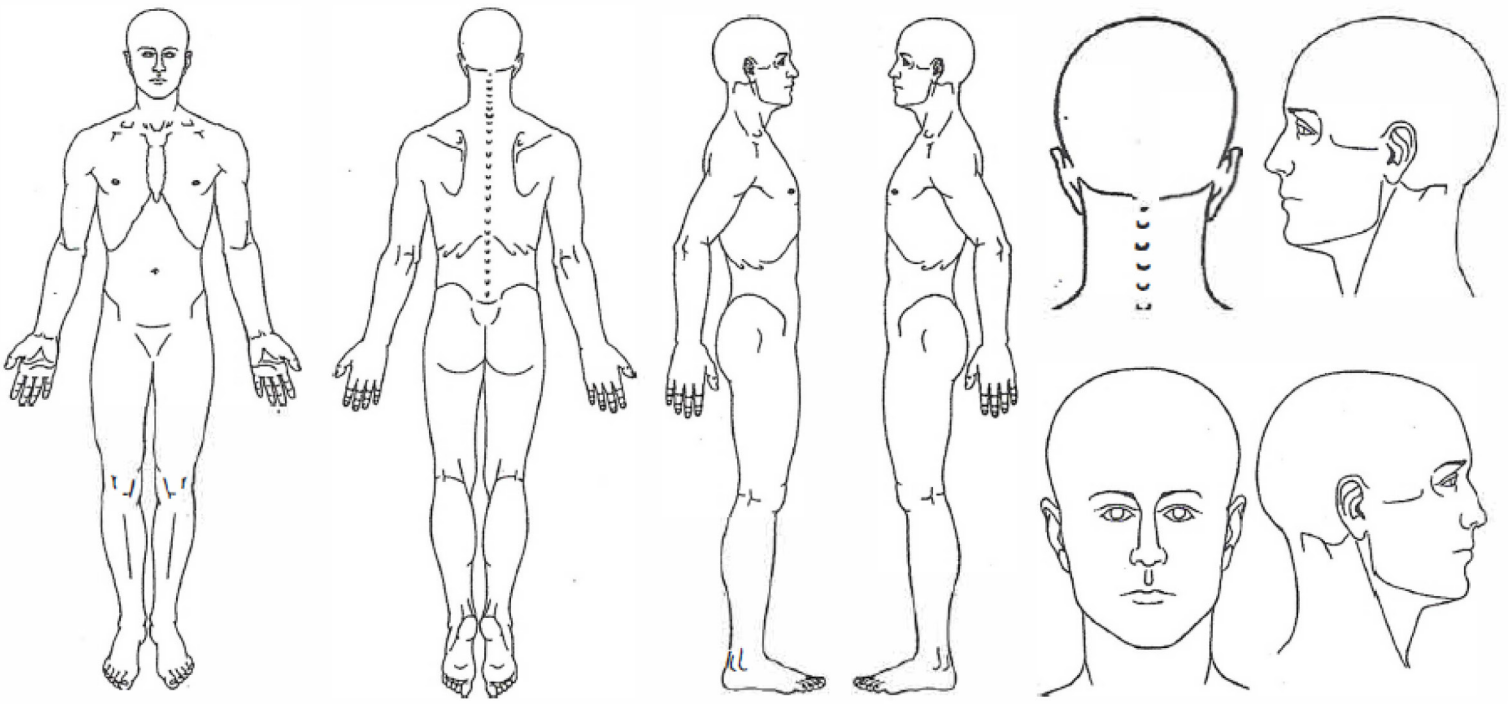
Please indicate the location and sensation of your body using the following symbols:

^^^^^^ Numbness
OOOOO Pins and Needles
XXXXXX Burning
******* Aching/Dull
////////// Stabbing/Sharp
EEEEEE Electrical



Surgical History: _____

_____

_____

Relevant Medical History: _____

_____

_____

Chief Complaint(s): _____

_____

_____

Pain Rating: 0 1 2 3 4 5 6 7 8 9 10

Paient Goals: _____

_____

_____

Activities Limited by Injury/Pain: _____

_____

_____

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Consent to Treatment

I hereby voluntarily consent to the performance of such diagnostic procedures and/or medical treatment as my therapist (PT), their assistants or designees at Keystone Therapy may deem necessary or advisable. This care may include, but is not limited to, routine testing and other therapeutics, evidence -based interventions and best practice guidelines. I authorize my therapist(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my care is directed by my physician/provider and that other personnel render care and services to me according to the therapist's instructions.

- I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me with regard to results of such diagnostic procedures or medical treatment.

I acknowledge that I have read or have had read to me this consent, and fully understand its details. I have had the opportunity to ask questions, and have had these questions addressed.

Patient Signature:_____ Date:_____

Patient Name:_____ Date of Birth: _____

If patient is unable to sign:

❑ Consent of Legal Guardian, Power of Attorney for Health Care, or Patient Advocate

❑ Consent of Caregiver or Nearest Relative

Name:_____ Relationship: _____

Telephone:_____ Address: _____

Signature:_____ Date:_____

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Assignment of Benefits

Patient Name: _____ Date of Birth: _____

I hereby assign and request that payment of authorized insurance benefits, including Medicare if applicable, be made on my behalf to Keystone Therapy for any medical services provided.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to Keystone Therapy, the Centers for Medicare and Medicaid Services, any other insurance carrier with whom I have coverage.

I understand that I am financially responsible to Keystone Therapy for any charges not covered by health care benefits, and I am only responsible for any deductible, co-pay or other amounts for services not covered by my insurance. I understand that Keystone Therapy agrees to accept the payment made by Medicare and any other insurance coverage as its full charge. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. It is my responsibility to notify Keystone Therapy of any changes in my health care coverage. I understand that by signing this form I am accepting financial responsibility as explained above for all payment for services received.

I acknowledge that I have read or have had read to me this assignment of benefits, and fully understand its details. I have had the opportunity to ask questions, and have had these questions addressed.

Patient Signature: _____ **Date:** _____

If patient is unable to sign:

Responsible Party: _____ Relationship: _____

Telephone: _____ Address: _____

Signature: _____ Date: _____

Please attach copy of insurance cards

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Practice Policies

Please take the time to read, initial, and sign our Practice Policies to acknowledge your understanding of them. We have found this policy to be most effective for both patients and providers. Outstanding balances can cause embarrassment and communication breakdowns, and potentially decrease adherence to the prescribed treatment program. If you have any questions regarding these agreements, please discuss them with Keystone Therapy staff.

Your insurance policy is a contract between you and your insurance company. Keystone Therapy is not a party to that contract. As a service to you and upon your request we can bill your insurance provider. It is your responsibility to provide our office with your insurance details and present your insurance card to our staff so we can bill your insurance carrier completely and accurately. When possible, our staff will call to verify your insurance coverage prior to your appointment. Please be aware that an estimate of benefits is not a guarantee of payment. If an insurance company provides you or our staff with inaccurate information they may not honor the benefits that were quoted.

It is your responsibility to be aware of your coverage and co-pay, as well as any deductible and maximums, per your insurance contract. All co-payments, co-insurance payments, deductibles, supplements/products, supplies, therapeutic equipment, and costs of services not covered by your insurance company are due and payable at the time of each visit.

PLEASE NOTE: There is a $50.00 fee for each no-show and/or appointment cancellation with less than 24 hours notice. When you schedule an appointment we reserve that time, carefully planned within the context of the week's schedule, exclusively for you. If you miss that appointment or cancel with less than 24 hours notice, it is too late to schedule another patient for your reserved appointment time. This results in a loss of income to both your practitioner and the clinic. In addition, we also incur administrative expenses related to scheduling, with less than 24 hours notice, regardless of the reason for the missed appointment, please be sure to notify us at least 24 hours in advance to avoid being charged.

Once we receive payment from your insurance company, we will apply this to your bill. If we find you have a credit, this will remain on your account for use toward future services and/or purchases. If instead you would like to be issued a refund, please let us know and we will be happy to issue you a check.

Patients must be responsible for following the referral, prescription, or treatment plan prescribed by their physician, practitioner, and/or insurance provider. Insurance companies may not pay for services when the treatment plan is not followed, thus patients are responsible for scheduling and attending appointments accordingly.

Patients are responsible for notifying Keystone Therapy if their insurance coverage or details change.

As a patient of Keystone Therapy, I acknowledge and agree to the above statements and understand that a part or all of my care may not be a covered benefit of my health plan. I acknowledge and agree to be financially responsible for my treatment.

_____ _____

Patient Name (Please Print) Relationship to Patient (if not self)

_____ _____

Patient Signature (or Responsible Party) Date