Wise Physical Therapy & Rehabilitation
1200 Airport Heights Ste 170, Anchorage, AK 99508
Phone (907) 562-2118 Fax (907) 562-2128

*First Name _____ * Last Name _____ MI ___ Nick-name _____

*Social Security #_____ *Date of Birth: _____

*Physical Address: _____

City/St/Zip: _____

*Mailing Address (if different): _____

City/St/Zip: _____

*Cellular Phone#: _____ *Work Phone: _____

*Email address: _____

O Male
O Female
O Unspecified

O Married
O Single
O Other

O Student
O Employed
O Retired/Unemployed

*REFERRING PHYSICIAN PROVIDER: _____

CLINIC: _____ Phone Number: _____

Appointment Reminders:

*Which phone # do you prefer to be contacted at? Home / Cell / Work (circle one)

* Would you like to receive Appointment Confirmation Calls? O Yes O No

* Would you like to receive Appointment Confirmation Texts? O Yes O No

* Is it ok to leave voice mail message? O Yes O No

Statements/Correspondence: *Where should patient statements/correspondence be sent? Email / Mail / Both (circle one)

*** Emergency Contact Information**

Name: _____
Relationship: _____
Address: _____
City/St/Zip: _____
Contact Number(s): _____

*** POA/Guardian Information**

(If Applicable, provide documentation)

Name: _____
Relationship: _____
Address: _____
City/St/Zip: _____
Contact Number(s): _____

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*Is this related to a *Work Comp Claim (WC)* or a *motor vehicle accident (MVA)*? O Work Comp O MVA O Neither

Date of accident or injury: _____ Name of insurance covering claim: _____

Claim Adjustor Name: _____ Phone Number: _____

Claim #: _____

(For WC only) Employer: _____

(For MVA only) Name of "at fault" party: _____ "At fault" party's insurance co.: _____

(For MVA only) Name of your insurance company (even if someone else was at fault): _____

(For MVA only) Do YOU have a "PIP", Bodily Injury, or Med coverage? O Yes O No Is there an attorney involved? O Yes O No

Attorney's name: _____ Attorney's phone number: _____

*Primary Insurance? O Yes O No	*Secondary Insurance? O Yes O No
Insurance Co. Name: _____	Insurance Co. Name: _____
Member ID#: _____	Member ID#: _____
Group#: _____	Group #: _____
Patient's relationship to Insured? [ ] Self [ ] Spouse [ ]Parent [ ] Other	Patient's relationship to Insured? [ ] Self [ ] Spouse [ ]Parent [ ] Other
If other, please describe: _____	If other, please describe: _____
Insured's Name: _____	Insured's Name: _____
DOB_____ SSN#_____	DOB_____ SSN#_____

MEDICARE PATIENTS

***Are you on Medicare? O Yes O No** ***If yes, have you received Home Healthcare in the last 30 days? O Yes O No**

This information is vital as it does affect the billing portion of your time with us. If you have received home health care in the last 30 days and fail to inform Wise Physical Therapy ***you will be solely responsible*** for full payments of services received.

***Initial acknowledgement of Medicare home health charges_____**

MEDICAL/PHYSICAL CHANGES/UPDATES

For your safety, it is important that **any** medical/physical changes experienced during your care with Wise PT are brought to our attention, immediately. If you have been in an accident, hurt, or re-injured, or if your medications have changed in any way, it is your responsibility to bring this to our attention so that we may provide you with appropriate care.

***Initial acknowledgement of medical changes** _____

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Assignment of Benefits/Right to Payment, Patient Responsibility, and Release of Information Form

Dear Patient:

Wise Physical Therapy & Rehabilitation (WPT) can submit a claim to your insurance company on your behalf for services and treatment provided to you. While we are happy to provide this courtesy to our patients, ***we do require your signature agreeing to the assignment of benefits*** (AOB). As the "Assignee", by signing below, you are authorizing your insurance company to send payment directly to us instead of yourself. Should the insurance company send a reimbursement check directly to you for services rendered here, you agree to send it to WPT immediately after endorsing the back of the check as follows:

ENDORSEMENT: Pay to the order of: Wise Physical Therapy & Rehabilitation, Inc.
MAIL CHECK TO: Wise Physical Therapy
1200 Airport Heights Drive, Suite 170
Anchorage, AK 99508

As the "Assignee," I authorize WPT to bill my insurance company and authorize payment from the insurance carrier directly to WPT. I authorize WPT to release medical or other information necessary to process this claim. I understand and agree that health and accident insurance policies are an agreement between an insurance company and myself. I understand that I am ultimately responsible for my charges, and I agree to pay my deductible, co-payment, co-insurance, and any charges not reimbursed by my insurance carrier. *I understand that I am responsible for knowing and meeting the requirements of my insurance plan*. **WPT is not responsible for incorrect information given by my insurance carrier regarding my benefits**. In the event of my default, I agree that I will be responsible for all collection, court costs, and attorney fees. (The above may not apply for those patients that are considered Worker's Compensation or who have benefits with a balance billing contract, such as an HMO. However, be advised if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.)

Re: Third-Party personal injury claims:

In the event I am seeking treatment from WPT for injuries which may give rise to a third-party personal injury claim, the following applies:

- Under AS 34.35.450 - .482, WPT may assert a lien for unpaid medical charges against the liable party, the liable party's insurer, and the patient's attorney. The patient may be entitled to a pro rata reduction of WPT Lien for attorney's fees and costs incurred in the pursuit of patient's third-party personal injury claim. *ANMC v Settlement Funds, 2004 WL 179026 (Alaska, 1/30/04).*
- **As WPT is willing to provide services *without* payment in full at the time services are rendered, I agree to wave any rights to reduce WPT's Lien for costs and attorney's fees as set forth above.**
- I acknowledge that WPT does and will balance bill for all unpaid claims, regardless of the outcome from any settlement proceedings. If the decision to obtain legal representation is made, I agree to be solely responsible for any and all attorney fees arising from any settlement proceeding and will not hold WPT responsible for any portion of incurred attorney fees.
- By signing below, I acknowledge that my rights to pro rata reduction of Doctor's Lien for attorney's fees and costs incurred in the pursuit of a third-party personal injury claim have been explained.
- By signing below, I agree to waive pro rata reduction of Doctor's Lien for attorney fees and costs incurred in my pursuit of a third-party personal injury claim and to pay WPT **in full** upon settlement of any third party personal injury claim.
- If applicable, **I agree to pay my attorney, any monies due under *ANMC v Settlement Funds, 2004 WL 179026 (Alaska, 1/30/04)* and/or pro rata reduction of Doctor's Lien for attorney fees and costs incurred,** whereby freeing WPT of any financial responsibility to my attorney.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

***Printed Name**_____

***Signature** _____ ***Date** _____
(Patient/Guardian/Responsible Party)

Thank you for choosing Wise Physical Therapy for your therapy services. We strive to provide the best care for our patients. The staff will assist you with any area of need. Please do not hesitate to ask for assistance at any time if you do not understand something.

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HIPAA Compliance Policy

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.
When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

1. **Get an electronic or paper copy of your medical record:**
    a. You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
    b. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
2. **Ask us to correct your medical record:**
    a. You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
    b. We may say "no" to your request, but we'll tell you why in writing within 60 days.
3. **Request confidential communications**
    a. You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
    b. We will say "yes" to all reasonable requests.
4. **Ask us to limit what we use or share:**
    a. You can ask us not to use or share certain health information for treatment, payment, or our operations.
    b. We are not required to agree to your request, and we may say "no" if it would affect your care.
    c. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
    d. We will say "yes" unless a law requires us to share that information.
5. **Get a list of those with whom we've shared information:**
    a. You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
    b. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
6. **Get a copy of this privacy notice:**
    a. You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

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7. **Choose someone to act for you**
    a. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
    b. We will make sure the person has this authority and can act for you before we take any action. File a complaint if you feel your rights are violated
    c. You can complain if you feel we have violated your rights by contacting us using the information at the top of this page.
    d. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
    e. We will not retaliate against you for filing a complaint.

8. **For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:**
    a. Share information with your family, close friends, or others involved in your care
    b. Share information in a disaster relief situation
    c. Include your information in a hospital directory
    d. Contact you for fundraising efforts
9. **If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. In these cases, we never share your information unless you give us written permission:**
    a. Marketing purposes
    b. Sale of your information
    c. Most sharing of psychotherapy notes
10. **In the case of fundraising:**
    a. We may contact you for fundraising efforts, but you can tell us not to contact you again.
11. **How do we typically use or share your health information? We typically use or share your health information in the following ways.**
    a. We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.
    b. We can use and share your health information to run our practice, improve yourcare, and contact you when necessary. Example: We use health information about you to manage your treatment and services.
    c. We can use and share your health information to review the competence or performance of those who render healthcare services to you. Example: We use health information about you to

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monitor the quality of healthcare treatment and services provided to you.

d. We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for yourservices.

12. **How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes.**

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

13. **We can share health information about you for certain situations such as:**
    a. Help with public health and safety issues
    b. Preventing disease
    c. Helping with product recalls
    d. Reporting adverse reactions to medications
    e. Reporting suspected abuse, neglect, or domestic violence
    f. Preventing or reducing a serious threat to anyone's health or safety
    g. Do research
        i. We can use or share your information for health research.
    h. Comply with the law
        i. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
    i. Respond to organ and tissue donation requests
        i. We can share health information about you with organ procurement organizations.
    j. Work with a medical examiner or funeral director
        i. We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
    k. Address workers' compensation, law enforcement, and other government requests
14. **We can use or share health information about you:**
    a. For workers' compensation claims
    b. For law enforcement purposes or with a law enforcement official
    c. With health oversight agencies for activities authorized by law
    d. For special government functions such as military, national security, and presidential protective services
15. **We can share health information about you in response to a court or administrative order, or in response to a subpoena.**
16. **We are required by law to maintain the privacy and security of your protected health information.**
17. **We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.**

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18. **We must follow the duties and privacy practices described in this notice and give you a copy of it.**
19. **We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.**

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date of this Notice: July 1, 2023

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HIPAA Compliance

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the Notice of Privacy Practices for Wise Physical Therapy & Rehabilitation, Inc. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Wise Physical Therapy & Rehabilitation, Inc., to release any of my protected healthcare information.

_____

Patient's or Authorized Representative's Printed Name

_____

Patient's or Authorized Representative's Signature

_____

*Date

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HIPAA Authorization to Share Access to Patient's Information

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: _____ Relationship: _____

Contact Information: _____

Name: _____ Relationship: _____

Contact Information: _____

Name: _____ Relationship: _____

Contact Information: _____

Health information to be disclosed upon the request of the person(s) named above:

_____ Scheduling/Cancelling Appointments
_____Medical Records
_____ Financial Information
_____ Other: _____

I understand that:

- This authorization gives Wise Physical Therapy and Rehabilitation the right to discuss my medical information with one or more people listed above.
- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting your office.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.
- I may refuse to sign this authorization and you will not condition treatment or payment on my providing this authorization.

The form of information that may be exchanged (Initial all that apply):

_____ Written _____ Verbal _____ Computerized Data (i.e., e-mail/SMS)

This authorization shall be effective until (Check one):

_____ One year from the date signed.
_____ Specific date or event: _____

(Note: you may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____

Patient or Legal Representative's Printed Name **Patient's Date of Birth**

_____ _____

Patient or Legal Representative's Signature **Date**

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Missed Visit Policy

At Wise Physical Therapy, our goal is to help all patients reach a fully recovered state. Your physical therapist will provide you with your plan of 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 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. We are happy to share a copy of this study with you. We want to make sure that you understand that it is extremely important that you attend all appointments. This policy ensures that all patients receive the care they need.

Please read, initial next to each, and sign at the bottom indicating your understanding.

- As experts, we know that **you will not reach full recovery if you do not attend your appointments.** To have the best chance at recovery, you will need to attend each visit. Our front office staff will work with you to schedule out all your appointments after your evaluation today.
- **Please note:** Our goal is to begin your treatment sessions on schedule. For all appointments after your initial evaluation, we expect that you will arrive with enough time to change clothes for your session (if needed) and be ready to begin on time. If you're late for your appointment, you're missing the time that we have specifically scheduled for your care. 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 another patient in need.
- If you're running late, we expect you to call us immediately so we can consult with your clinician. As visits are billed in 15-minute time increments, ***if you arrive more than 5 minutes past your scheduled appointment time, your session will most likely need to be rescheduled.*** We reserve the right to charge a missed visit fee of **$100** for the lost session. Chronically late patients may be considered for discharge.
- While we understand that illness can strike at any time, we still expect that you will provide notice at the beginning of symptoms if you cannot attend a scheduled appointment. Text and voice mail capabilities are available contact options after hours.
- Providing care for all patients is extremely important to us. Short-term cancellations 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 during business hours.*** For your convenience, you can notify us by texting or calling **907-562-2118, 24/7**. Please have your schedule ready as we will reschedule you right away.
- A missed visit fee of **$100** will be charged if you do not provide at least a days' notice of your cancelation. We reserve the right to waive the missed visit fee on a case-by-case basis.
- If your visits are covered under workers 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 to get in for the care they need and deserve.**

By signing below, I am indicating that I understand this policy.

Patient/Legal Representative's Signature	Printed Name	Date

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*NAME: _____ *DATE: _____

*DOB: _____

Where is your pain?

Please mark on the drawings below the areas you feel your pain.