KEMPTON
Physical Therapy
SPORTS MEDICINE & REHABILITATION SPECIALISTS

WELCOME TO OUR OFFICE

We want to welcome you to Kempton Physical Therapy. We appreciate the trust that you and your doctor are placing in us. We will always do our best to help you reach your goals and work toward a speedy recovery. This letter will give you an outline of some of the basic information regarding our practice. Please do not hesitate to ask any of our staff should you have specific questions or any concerns regarding your treatment plan, your appointments, your insurance billing, or any other matter we may be able to help you with.

Our regular therapy hours are:	Monday - Friday:	7:00 am - 6:00 pm
	Tuesday & Thursday:	7:00 am - 12:00 pm

Your doctor has given us a written prescription for physical therapy. We must follow this prescription in regard to the frequency and duration of your treatments. Your insurance company requires this prescription to determine medical necessity. Our office will make every attempt to keep track of the number of appointments you are using. You will need a new prescription from your doctor when the prescribed visits have been exhausted, when the expiration date set by your doctor has passed, or every thirty days. In order to assist us in correspondence with your doctor, please inform your therapist at least two days prior to any follow up appointments with the doctor who referred you. On or before the date of your appointment with your doctor, your therapist will write a progress report and it will be faxed to your doctor, along with your therapist's recommendations regarding continuation of therapy.

Our office will call and verify your physical therapy benefits with your insurance company. We are usually given a general description of your benefits. If you have any concerns regarding your particular insurance plan, please contact your insurance company directly. There is usually a toll-free number on the back of your insurance card.

Again, we want to welcome you to our office. We will always try to do our best to make the time you spend with us a pleasant experience. Please do not hesitate to call us any time you many need us in the future.

Sincerely,

The Staff at Kempton Physical Therapy

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SUMMARY OF BASIC PATIENTS' RIGHTS AND RESPONSIBILITIES

We at Kempton Physical Therapy are committed to serving you with compassion, care, skill and respect. As one of our patients, you have choices, rights and responsibilities.

You have the *RIGHT*:

- To be treated with dignity and respect
- To know the names and professional status of people serving you
- To privacy
- To confidentiality of your records
- To receive accurate information about your health-related concerns
- To know the effectiveness, possible side effects, and problems of all forms of treatment
- To participate in choosing a form of treatment
- To receive education and counseling regarding your treatment
- To consent to, or refuse any care of treatment
- To review your medical records with a clinician
- To information about services and any related costs

You also have the *RESPONSIBILITY*:

- To seek medical attention promptly
- To be honest about your medical history
- To ask about anything you do not understand
- To follow health advice and medical instructions
- To report any significant changes in symptoms of failure to improve
- To respect clinic policies
- To keep appointments or cancel in advance
- To seek non-emergency care during regular business hours
- To provide useful feedback about services and policies

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FILING A CONCERN

If you should encounter a problem with a member of our staff or a difficulty in using our services, there are several courses of action you may take.

1. If the problem is related to your healthcare, please attempt to discuss your concerns with the healthcare practitioner with whom you have been working with. You may also request to be referred to the staff member's administrator.

2. There may be times when a problem should be brought to the attention of the administrator. This can be done verbally or in written form by filling out a concern and/or feedback form available at the front desk. If such an incident involved medical care you received while a patient here, the administrator will want to review your medical records, and any other documentation you may want to provide to clarify the matter. Most problems can be resolved via discussion with the administrator.

3. Some serious concerns may be referred to and reviewed by the medical director of the clinic who functions in an advisory role to the clinic staff.

4. The ultimate decision for a concern that cannot be resolved within the scope of the areas previously noted will be determined by the governing body of the clinic.

5. In addition we are always interested in your feedback. Please feel free to give us verbal or documented recommendations.

Regardless of how you voice your concerns about your experience at this facility, you are entitled to a review of, and a response to your concerns. The administrator is committed to investigating and responding to any issues you may encounter. Our facility will make every reasonable effort to resolve any problems you may experience and improve deficient areas whenever possible. Any questions regarding this policy should be directed to the clinic administrator at (480) 807-9000.

Registration for Services at Kempton Physical Therapy

6960 E. Broadway Rd. Mesa, AZ 85208 • 1100 N. Broad St. Suite A Globe, AZ 85501
Phone (480) 807-9000 • Fax (480) 807-9234

Welcome to our office. In order to serve you properly, we will need the following information.**(Please Print)** All information will be strictly confidential.

Last Name:	First Name:	MI:

Address:	City:	State:	Zip Code:

Patient's Social Security #:	Home Phone:	Cell Phone:	Birth date:

Referred by: Dr._____ Family Member _____Friend_____ Walk In_____ Previous Patient_____ Internet_____	Sex: M F	Marital Status: M S W D

What type of condition/ injury are you being seen for:	Name of Referring Physician:

Date of Injury/ First Symptoms:	Employment Related? **Y N**	Auto Accident? **Y N**	Other?

Have you had any therapy/chiropractic this calendar year? **Y N**	If so, how many visits?	Was the therapy performed at your home? **Y N**

Name of Employer:	City & State:	Work Phone: Ext:

Person to contact in case of emergency:	Phone #:

Primary Insurance Company: / Secondary Insurance Company:	Is the insurance in your name? **Y N**

Personal email address:	☐ I want to receive reminders for my appointments ☐ I want to receive email communications

Name of insured, if not self:	Relationship to insured:	Insured social security #:

Birth date of insured:	Insured employer name:

Please ***INITIAL*** in applicable spaces below.

_____ I have read and understand the Patient Rights and Responsibilities.

_____ I have read and understand the procedure for filing a concern.

_____ I have read and understand the Notice of Privacy Practices in protecting my health information.

Authorization for Assignment of Benefits/Information Release:

I, the undersigned, give consent for physical therapy and authorize payment of medical benefits to Kempton Physical Therapy for any services furnished to me by the physician. I understand that I am financially responsible for any amount not covered by my insurance. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits. I also give permission to call my cellular and home phone to contact me and/or leave a detailed message.

_____ _____

Patient Signature Date

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Patient Name: _____

Age: _____ Current weight: _____ Height: _____

Current Medications: ☐ I do not take any medications

Name of Medication	Dose	How Often Taken

Recent Hospitalizations/ Surgeries (within past year): ☐ None

Description	Date

Injuries/ Illnesses: Please check if you have ever had:

☐ Arthritis ☐ Broken bones/fractures ☐ Osteoporosis
☐ Blood disorders ☐ Circulation/vascular problems ☐ Heart problems
☐ High blood pressure ☐ Lung problems ☐ Stroke
☐ Diabetes/high blood sugar ☐ Hypoglycemia/low blood sugar ☐ Head injury
☐ Multiple sclerosis ☐ Muscular dystrophy ☐ Parkinson's disease
☐ Seizures/epilepsy ☐ Allergies ☐ Developmental/growth problems
☐ Thyroid problems ☐ Cancer ☐ Infectious disease (e.g. tuberculosis, hepatitis)
☐ Kidney problems ☐ Repeated infections ☐ Ulcers/Stomach problems
☐ Skin diseases ☐ Depression ☐ Pacemaker
☐ Other:_____

Within the past year, have you had any of the following symptoms? (Please check all that apply)

☐ Chest pain ☐ Heart palpitations ☐ Cough
☐ Hoarseness ☐ Shortness of breath ☐ Dizziness or blackouts
☐ Coordination problems ☐ Weakness in arms or legs ☐ Loss of Balance
☐ Difficulty walking ☐ Joint pain or swelling ☐ Pain at night
☐ Difficulty sleeping ☐ Loss of appetite ☐ Nausea/vomiting
☐ Difficulty swallowing ☐ Bowel problems ☐ Weight loss/gain
☐ Urinary problems ☐ Fever/chills/sweats ☐ Other: _____

Signature:_____ Date:_____

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Financial Policy:

We at Kempton Physical Therapy are dedicated to providing you with excellent service. We feel that a part of that excellent service is ensuring that you have a good understanding of our financial policy.

Patient Responsibilities:

You must bring in your **current** insurance card. We must make a copy of both the front and the back of your card in order to bill your insurance. It is your responsibility to notify us immediately of any changes in your insurance. If accurate information is not provided for the timely submission of claims, you will be held responsible for the full amount of any charges incurred. We will file your primary insurance and secondary insurance if it is transmitted electronically from your primary insurance company. If you are a Medicare subscriber, we will file your secondary insurance for you.

You will be asked to sign an authorization for your insurance carrier to make payment directly to Kempton Physical Therapy. Any payments sent directly to you should be forwarded to Kempton Physical Therapy immediately along with all of the paperwork from your insurance company, so that your account can be credited.

Your insurance will be billed and if payment is not received within ninety days, you will become responsible for those charges. Should this occur, please contact your insurance company as to the reason for non-payment. Resources are available through your insurance company to help you to understand your coverage. Coverage is verified by Kempton Physical Therapy, but verification **does not guarantee payment**. Please contact your insurance company for clarification of benefits.

Payment Policy:

Co-pays: All co-pays are due at time of service. We will verify your insurance and advise you of the co-pay amount and any restrictions your insurance company has placed on physical therapy. Please contact your insurance for clarification of your co-pay amount.

Liens: We occasionally accept liens for accidents. This is done on a case-by-case basis. This requires a signed lien which includes the date of injury as well as the name and address of your attorney. **Signatures are required by you as well as your attorney. You are responsible for having your attorney sign the lien.** If we accept a lien, we will not file with your insurance company. The lien will be used in lieu of your insurance. We will not accept liens for "co-pays only".

Non-Insured: If you are not paying with insurance, we will require payment in full at time of service.

Balances Due: After we have received payment from your insurance, any remaining balance is due thirty days from the date of the first statement. Interest will accrue at 1.5% for balances over 90 days old. If this matter is referred for collections, the prevailing party shall be entitled to reasonable attorney fees and costs.

Signature: _____ Date: _____