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Patient Intake & Authorizations

Full name: _____

Date of birth _____ Sex: M F Social Security #:_____

Home Address _____ Apt #_____

City _____State_____ Zip _____

Home phone#: _____ Work phone# _____

Emergency contact _____ Phone #:_____

Description of injury/pain/deficit/problem: Date of your injury: _____

_____

_____

_____

Personal Goals:

_____

_____

_____

Primary Care Provider: _____ Phone #:_____

Primary Insurance Company: _____ Policy#:_____ Group#_____
Policy Holder Name (if not you): _____

Secondary Insurances _____

**** Workers Comp Only ****

Employers name _____ Phone #:_____

Employer address_____

Ins Co. Name _____ Phone #:_____

Address_____

WCB Case #:_____ Carrier Case #:_____

Initial Visit $160; All follow-ups: $125.

ALL PATIENTS ARE PERSONALLY RESPONSIBLE FOR FULL PAYMENT OF ALL CHARGES. CANCELLATIONS SHOULD BE MADE 24 HOURS IN ADVANCE. IF NOT, THERE WILL BE A $20 CANCELLATION FEE.

NOTICE OF ADVICE: THE TREATMENT MAY NOT BE COVERED BY THE PATIENT'S INSURER WITHOUT A REFERRAL. SUCH TREATMENT MAY BE A COVERED EXPENSE IF RENDERED PURSUANT TO A REFERRAL. A SUPERBILL MAY BE SUBMITTED BY YOURSELF TO INSURANCE AND INSURANCE MAY OR MAY NOT REIMBURSE IN FULL OR PARTIAL PAYMENT. THE TREATMENT MAY NOT BE COVERED BY THE PATIENT'S HEALTH CARE PLAN OR INSURER WITH SUPERBILL SUBMISSION.

I, the undersigned, agree to be treated in my own home by Champ Therapy and Wellness PLLC and hereby authorize my insurance carrier to pay the provider directly for services rendered. I have read the above and agree to comply fully, signed:

Signature: _____ Date: _____

Treater Signature: _____ Date: _____

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Patient Authorization and Guarantee

Release of Information: I hereby authorize the release of any information by telephone or in writing, including reports of diagnosis, treatment prognosis, recommendation, benefits payable, as well as any other data pertinent to my treatment, by Champ Therapy and Wellness PLLC to the physician who referred me for therapy as well as any organization responsible for payment of my account or medical care related to my treatment. I also authorize the release of any information by telephone or in writing for utilization and quality review purposes.

Assignment of Insurance Benefits: I hereby authorize that the payment of authorized benefits be made directly to Champ Therapy and Wellness PLLC of any services that are reimbursable by Medicare, Medicaid, or any third party source.

Valuables: I hereby understand that Champ Therapy and Wellness PLLC is not responsible for valuables and personal property within my house. I hereby understand that Champ Therapy and Wellness PLLC is bringing equipment and property into my home that may result in faulty parts or damage to myself or property and understand that situations may occur of no direct fault to Champ Therapy and Wellness PLLC.

Consent for Treatment: I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while I am a patient of Champ Therapy and Wellness PLLC.

Guarantee of Account: In consideration of services rendered to me by Champ Therapy and Wellness PLLC, I hereby guarantee payment for any and all services rendered to me which are not covered or allowable by insurance, together with collection costs, including reasonable attorney fees. I also understand that all bills are due and payable upon presentation. I understand that the patient responsibility portion of my bill shall be due and payable at time of services.

Medicare: I hereby certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any such information needed for this or a related Medicare Claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and co-insurance.

By signing this document, I acknowledge my consent to the above.

Signature: _____ Date: _____

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Method of Communication

I prefer to be contacted through the following method(s):

_____ Phone Call _____ Text _____ E-mail

Please initial appropriate areas below:

_____ I understand that if I have opted for text or e-mail communication that it is not 100% secure and personal information may be available to outside sources not involved with my direct care. The following signature designates that I am agreeing to this and have approved communication through text or e-mail that will include personal information about myself or care/services I am being seen for by Champ Therapy and Wellness PLLC.

_____ I authorize Champ Therapy and Wellness PLLC to leave me a voicemail on my phone I have provided.

_____ I authorize the following people to take messages or call Champ Therapy and Wellness PLLC regarding my care and services provided by Champ Therapy and Wellness PLLC. Names of those people:

_____

_____

I specifically DO NOT want the following people to be contact or told anything about my care:

_____

I hereby attest that I have thoroughly read and understand this Method of Communication form.

Signature: _____ Date: _____

Name (printed): _____

Staff signature:_____

GOOD FAITH ESTIMATE

The No Surprises Act, which was signed into law on December 27, 2020, amends the Public Health Service (PHS) Act by establishing requirements for health care providers and facilities to protect patients from surprise medical bills and to provide good faith estimates (GFE) to potential patients. On September 30, 2021, the Departments of Health and Human Services, Labor, and Treasury issued an interim final rule with a comment period outlining the details of the GFE and other provisions of the statute.

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

You are entitled to receive this "Good Faith Estimate" of what the charges could be for Champ Therapy and Wellness PLLC services provided to you. While it is not possible for us to know, in advance, how many sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of sessions you attend, your individual circumstances, and the type and amount of services that are provided to you. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here. This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of therapy visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

- **You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.**
- **Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.**
- **If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.**
- **Make sure to save a copy or picture of your Good Faith Estimate**

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 1-800-985-3059

Provider Name: Kelly Hogan PT, DPT, MOT, OTR/L	License #: 5501017365; 5201009162
Provider Phone #: (248) 429-7211	
Provider Tax ID# (if applicable):	Provider NPI # (if applicable): 1447911136

Patient Name:	
Patient Address:	
Patient Phone #:	Patient Email:
Patient Diagnosis (if known/applicable):	
Services Requested:	

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The fee for a 60- min evaluation (in person) is $160. Follow up visits of 45-60 minutes is $125. Most clients will attend two therapy sessions per week, but the frequency of visits that are appropriate in your case may be more or less than twice per week, depending upon your needs. If you attend therapy for a longer period, your total estimated charges will increase according to the number of visits and length of treatment. Based on a fee of $ 125 per visit (with evaluation at $160), the following are expected charges of Champ Therapy and Wellness PLLC services:

Number of Weeks	Total estimated charges for 2 session per week
1 Week of Service	$ 285
4 Weeks of Service	$ 1035
6 Weeks of Service	$ 1535
8 Weeks of Service (Approx. 2 Months)	$ 2035
13 Weeks of Service (Approx. 3 Months)	$ 3285

You have a right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400 or more beyond the estimated charges). You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

Date of this Estimate: _____

I understand and agree to these charges.

Signature: _____ Date: _____

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AGREEMENT OF RELEASE AND WAIVER OF LIABILITY

This form covers all therapy sessions, personal training and/or programs offered by Champ Therapy and Wellness PLLC. Please fill out the following, being sure to read and initial each paragraph.

I, _____, hereby agree to the following:

____ I am participating in physical or occupational therapy sessions, personal training or other programs offered by Champ Therapy and Wellness PLLC during which I receive education, information and instruction about exercise, wellness and prevention. I recognize that these physical or occupational therapy sessions, personal training and other programs may require physical exertion, which may be strenuous. Although unlikely, physical injury could occur. I am fully aware of the risks and hazards involved and I agree to assume any responsibility to any injury. I will follow all instructions and modifications recommended by Champ Therapy and Wellness PLLC.

____ I understand that it is my responsibility to consult with a physician prior to and regarding my participation in physical or occupational therapy sessions, personal training and/or other programs offered by Champ Therapy and Wellness PLLC. I represent and warrant that I am physically able to participate in exercise classes and I have no medical condition that would prevent my full participation in these physical or occupational therapy sessions, personal training and/or other programs.

____ I understand that I have signed up for physical or occupational therapy sessions, personal training and/or other programs that will be performed at my own house. I understand that I will be using my own equipment and do not hold Champ Therapy and Wellness PLLC accountable for any malfunction of equipment.

____ I understand that I may use resistance bands, weights or portable equipment of Champ Therapy and Wellness PLLC and that items may break or not work properly. I understand that this is unlikely, but could result in injury or damage to my personal property. I understand the risk of this and agree to not hold Champ Therapy and Wellness PLLC accountable for any unforeseen malfunction.

____ I have read and understand the Exercise Guidelines for participation in Group Exercise class or personal training sessions.

____ I agree to inform Champ Therapy and Wellness PLLC of any physical limitations, physical discomforts and/or injuries before, during or after fitness classes, physical or occupational therapy sessions, personal training and/or programs, and I take full responsibility for nondisclosure.

____ I have read the above release waiver of liability and fully understand its contents.

____ I voluntarily agree to its contents. I voluntarily agree to the terms and conditions stated above.

Signature: _____ Date: _____

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HIPAA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers or myself.
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available from the office in print form). I have been given an opportunity to review such prior to signing this consent, and acknowledge that I have studied the Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Signature: _____ Date: _____