TRANSCEND
PHYSICAL THERAPY
v. to rise above or go beyond; exceed in excellence

116 South Lane Street
Blissfield, MI 49228
ph 517.486.5278
fax 517.486.5298

To Our Dear Patients:

Thank you for choosing Transcend Physical Therapy. In order to serve you best, we would like you to be aware of the following:

Arrival: Please sign in upon arrival. If we have not brought you into the treatment area within 10 minutes, feel free to ask us how much longer you will need to wait.

Attire: Please wear comfortable clothing appropriate for exercise and examination of the injured area.

Children & Visitors: Under most circumstances, all "non-patients" are requested to remain in the waiting area during treatment hours.

Appointments: Please schedule your appointments at the end of the initial evaluation. Regular attendance is vital to your progress in therapy. Try to avoid repeated cancellations for optimal results. If you are over 15 minutes late for your appointment, you may need to be rescheduled. Call us as soon as possible if you cannot make your appointment and please be prepared to reschedule at that time. Our receptionist is here from 8AM to at least 6PM Monday through Friday. We also have voicemail for any after-hours messages.

> **Unexplained absences for three or more consecutively scheduled appointments may result in a discontinuation letter sent to your referring physician and insurance company. At that point, a new prescription would be required to restart therapy.**

Insurance Coverage: We bill all insurances; however, your insurance company makes the final determination. You are ultimately responsible for payment. We call the insurance company to verify that you have physical/occupational/speech therapy benefits under your plan. There is no way to determine confirmation of payment ahead of time. If you have questions regarding your insurance coverage, please contact your insurance company regarding coverage of therapy prior to starting therapy. If you do not have insurance or are underinsured, please speak with us regarding your financial concerns. We will do whatever we can to provide care to all who need it and are very reasonable and flexible with repayment of accumulated charges. We want to provide care to you!

Physician Visits: Please notify us of upcoming visits to your physician at least one week prior to the appointment date. We need to reevaluate you and send a progress note to your physician in order to help them decide on the best course of action for your recovery.

Snow Emergencies: Due to heavy snowfall, the clinic may be closed and/or staff may be arriving late. If you are scheduled for treatment on such an occasion, please call early to check the status of your appointment.

Please inform your therapist if you feel you are not making any progress in therapy. We need to know this to provide you with the best possible care.

If you have any questions, please feel free to ask us! We are here to serve you.

Sincerely,
Jonathan and Emily Quinton

PATIENT INFORMATION

NAME (Last, First, Middle)		BIRTHDATE	SEX	MARITAL STATUS:	STUDENT STATUS ☐FULL-TIIME ☐PART-TIME
LOCAL ADDRESS	CITY, STATE ZIP			HOME PHONE	
PRIMARY EMPLOYER		WORK PHONE			
ADDRESS		CITY, STATE ZIP			
REFERRING PHYSICIAN'S NAME	REFERRING PHYSICIAN'S PHONE		DIAGNOSIS		

RESPONSIBLE PARTY INFORMATION (if Different than above

NAME (Last, First, Middle)		BIRTHDATE
LOCAL ADDRESS	CITY, STATE ZIP	HOME PHONE
RELATIONSHIP TO PATIENT	EMPLOYER	

PRIMARY INSURANCE (please present insurance card for copying)

NAME OF INSURANCE COMPANY			POLICY #	
NAME OF INSURED			GROUP #	
INSURED'S ADDRESS	INSURED'S BIRTHDATE	INSURED'S SEX	COPAY AMT	DEDUCTIBLE
INSURED'S CITY, STATE ZIP	INSURED'S PHONE		INSURANCE EFFECTIVE DATE	
RELATIONSHIP TO PATIENT	INSURED'S EMPLOYER		INSURANCE EXPIRATION DATE	

SECONDARY INSURANCE (if Applicable) (please present insurance card for copying)

NAME OF INSURANCE COMPANY			POLICY #	
NAME OF INSURED			GROUP #	
INSURED'S ADDRESS	INSURED'S BIRTHDATE	INSURED'S SEX	COPAY AMT	DEDUCTIBLE
INSURED'S CITY, STATE ZIP	INSURED'S PHONE		INSURANCE EFFECTIVE DATE	
RELATIONSHIP TO PATIENT	INSURED'S EMPLOYER		INSURANCE EXPIRATION DATE	

IF THIS INJURY IS THE RESULT OF AN ACCIDENT, CIRCLE WHICH	AUTO	WORK
INJURY DATE	CLAIM NUMBER (if Applicable)	

I CONSENT to the use or disclosure of my protected health information by Transcend Physical Therapy (TPT) for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of TPT; AND: that I am financially responsible to pay any deductible, co-pay or for any other charges that exceed those covered by my insurance plan. By signing below, I ACKNOWLEDGE that I have been provided with TPT's Notice of Privacy Practices, including an opportunity to object to certain disclosures of my protected health information.

_____ _____

Patient's Signature (or Responsible Party) Date

A photocopy or facsimile of this consent shall be considered as effective and as valid as the original signed form.

General Medical Questionnaire

Name: _____ Birthdate: _____ Age: _____ Date of Eval: _____

Height: _____ ft. _____ in. Weight: _____ lb. Phone: _____

Personal Medical History:

	Yes	No		Yes	No		Yes	No
Are you pregnant?			Dizziness			Respiratory		
Heart Problems			Seizure/Epilepsy			Stroke		
Pacemaker			Arthritis			Depression/Anxiety		
High Blood Pressure			Metal Implants			Sleeping Problems		
Diabetes: Type 1 Type 2 (circle)			Cancer If so, where:			Any other medical problems? (specify on next line)		
Other medical problems:								

List any prior surgical procedures_____
List relevant imaging (X-ray, MRI, etc.): _____
List allergies:_____
When did your symptoms begin/injury occur?_____
What are you having difficulty doing because of your symptoms/injury? _____
Describe occupation or note if retired: _____Are you presently working? Yes No
What is the highest grade/degree you have completed? _____
Is this a work or auto related injury? No Yes Explain:_____
Have you had any change in your diet/eating habits? No Yes Explain: _____
Do you have any cultural/religious beliefs that may affect your treatment? No Yes Explain: _____
Do you have any financial or transportation concerns that will affect your participation in treatment? No Yes Explain: _____
_____
What are your therapy goals (i.e., what would you like to get out of therapy?) _____

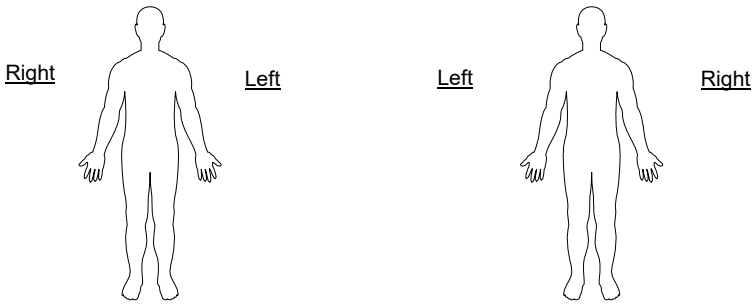
Patient Pain Index

How often does pain occur?
- ☐ Constant
- ☐ Comes during activity
  if so, what activity: _____
- ☐ Occurs randomly

Does Pain affect your sleep?
- ☐ Wakes from sleep
- ☐ Prevents sleep
- ☐ Better after sleep

How you would describe your pain?
- ☐ Sharp
- ☐ Dull
- ☐ Radiating
- ☐ Throbbing
- ☐ Burning
- ☐ Numbness

If your current condition is causing you pain, please put an "X" on drawing where you feel pain.



Please place an "X" on the SCALE below from 0 to 10 which best describes the amount of pain you are experiencing.

0 1 2 3 4 5 6 7 8 9 10
No Pain — Moderate Pain — Severe Pain

Please check the boxes for answers to the following questions:

PHYSICAL/COGNITIVE LIMITATIONS	LANGUAGE BARRIERS	YOUR MOTIVATION TO LEARN	PREFERRED LEARNING METHOD	HOW WOULD YOU LIKE YOUR HOME EXERCISE PROGRAM
☐ None	☐ None	☐ Eager	☐ Hearing	☐ Demonstration Only
☐ Vision	☐ Unable to speak/understand English	☐ Cooperative	☐ Reading	☐ Written Handout
☐ Hearing		☐ Skeptical	☐ Visual Demonstration	☐ Both
☐ Speech		☐ Unsure	☐ No Preference	
☐ Acute Illness	☐ Unable to read English			
☐ Dementia				

Patient's Signature: _____ Date _____

This portion to be completed by the physical therapist:

Does the patient require a social work referral?	Yes	No	Why: _____	
Is the patient aware of diagnosis?	Yes	No		
What is prognosis?	Poor	Fair	Good	Excellent
Is patient aware of prognosis?	Yes	No		

Physical Therapist's Signature: _____ Date _____

First Name:	Last Name:		Date:
Medication	**Dosage**	**Frequency**	**Route**

Allergies:

Consent for Treatment

I, _____, hereby consent to the rendering of health care, which may include routine diagnostic procedures and such medical treatment as is determined necessary by the treating physical therapist, his/her assistants, his/her associates, designees or consultants, and authorized representatives of this health care entity.

Payment of Benefits and Claims: I direct anyone paying or receiving money for benefits or claims that I have assigned to the health care entity to pay the money to Transcend Physical Therapy, PC or its designee for payment of my bill. It is understood that I am financially responsible for charges not covered by the insurance company or any third party payers.

Personal Valuables: The health care entity is not responsible for money, jewelry, clothes or other valuables I have brought with me during my visit.

Photographs, Videotapes: I understand that photographs, videotapes, digital, or other images may be recorded to document my care, and I consent to this. I understand the Transcend Physical Therapy, PC will retain the ownership rights to these images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy and that they will be kept for the time period required by law or as outlined in the organization's policy. Images that identify me will be released and/or used outside the organization only upon written authorization from me or my legal representative.

Observers: For purpose of advancing medical education, I consent to observers being present during the administration of any medical treatment.

Third Party Reviewers: I understand that third party reviewers may review my records for the purpose of clinic and/or rehabilitation center accreditation, certification or licensure.

I certify that I have read this Consent for Treatment, I understand it, and agree that by signing it I am bound by its terms.

_____

Patient/Legally Authorized Representative Signature Date

Patient unable to sign because

_____

Reason Signature

Release of Medical Records: I hereby authorize Transcend Physical Therapy, PC to release my medical records to any physician from which I have been referred.

_____

Patient/Legally Authorized Representative Signature Date

Receipt of Notice of Privacy Practices

I received a copy of the Transcend Physical Therapy, PC Notice of Privacy Practices on _____

Date

_____ _____

Printed Patient Name Patient/Legally Authorized Representative Signature

Release of Medical Records to Personal Contacts: I hereby authorize Transcend Physical Therapy, PC to release my medical records to the following personal contacts

_____

Contact Name Relation

_____

Contact Name Relation

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PHYSICAL THERAPY

116 South Lane Street
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Phone: 517.486.5278
Fax: 517.486.5298

Cancellation and Missed Appointment Policy

Our goal is to provide quality individualized physical therapy in a timely manner. "No-shows" and late cancellations inconvenience those individuals who need access to our care in a timely manner. We would like to remind you of our office policy regarding missed appointments. This policy enables us to better utilize available appointments for our patients in need of physical therapy.

Cancellation of an Appointment

In order to be respectful of the needs of other patients, please be courteous and call Transcend Physical Therapy promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely physical therapy. Early notifications also help us to staff properly.

Late Cancellations:

A late cancellation is considered when a patient fails to cancel their scheduled appointment with a 24-hour advance notice.

No Show Policy:

A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show."

- **First missed appointment: There will be no charge**
- **Second missed appointment: $25 fee will be billed to your account**
- **After the third or more missed appointment: You may be discharged from our practice**

We appreciate your thoughtfulness and consideration of our policy. If you have any questions regarding this policy, please ask our front desk staff.

X_____ X_____

Patient's Signature Date

EFFECTIVE DATE OF THIS NOTICE: JANUARY 1, 2014

TRANSCEND PHYSICAL THERAPY, PC
116 SOUTH LANE STREET
BLISSFIELD, MI 49228
PHONE 517 486-5278 FAX 517 486-5298
COMPLIANCE OFFICER: JONATHAN QUINTON, PT

NOTICE OF PRIVACY PRACTICES

As Required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your medical information is personal and we are committed to protecting your privacy. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your medical information and what rights you have regarding information. If you have any questions, please contact the Compliance Officer shown above.

We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment will be effective for all of your records that our practice has created or maintained and for any generated in the future. We will post a copy of our current Notice in our office in a visible location and you may request a copy of our most current Notice at any time.

OUR PLEDGE REGARDING HEALTH INFORMATION

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. This Notice describes your rights as our patient and our obligations regarding the use and disclosure of health information. We are required by law to:

- Make sure that health information that identifies you is kept private;
- Provide you with this Notice of our legal duties and privacy practices with respect to health information about you; and
- Comply with the terms of the Notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following categories describe the ways in which we may use and disclose your health information for treatment, payment or health care operations. We routinely use your medical information inside our office for these purposes without any special permission. For clarification, we have included some examples. Not every possibility is specifically mentioned. However, all of the ways we are permitted to use and disclose your medical information will fit within one of these general categories.

Treatment. We may use and disclose your medical information to treat you. Common reasons for use and disclosure may include performing exams, ordering or performing tests, ordering prescriptions, referring you to other medical professionals, or obtaining copies of information from other providers. Additionally, we may disclose your medical information to others who may assist in your care, such as your spouse, children or parents.

Payment. We may use and disclose your medical information in order to bill and collect payment for services. For example, we may provide your insurer with treatment information to certify eligibility. We also may use and disclose your medical information to obtain payment from third parties that may be responsible for costs, such as family members.

Health Care Operations. We may use and disclose your medical information to operate our business. Examples may include using your medical information to evaluate the quality of care you received from us or to conduct cost-management and business planning activities for our practice.

Appointment Reminders. We may use and disclose your medical information to contact you and remind you of an appointment.

Treatment Options and Health-Related Benefits. We may use and disclose your medical information to inform you of potential treatment options or health-related benefits or services that may be of interest to you.

Disclosures Required By Law. We will use and disclose your medical information when we are required to do so by federal, state or local law. For example, disclosure may be required by Workers' Compensation statutes and various public health statues in connection with required reporting of births and deaths, certain diseases, child abuse and neglect, domestic violence, adverse drug reactions, etc.

Health Oversight Activities. We may disclose your medical information to a health oversight agency for activities authorized by law. Oversight activities can include investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

Lawsuits and Similar Proceedings. If you are involved in a lawsuit or similar proceeding, we may use and disclose your medical information in response to a court or administrative order or to defend the office. We also may disclose your information in response to a discovery request, subpoena, or other lawful process by another party involved, but only if we have tried to inform you of the request or to obtain an order protecting the information the party has requested.

Law Enforcement and/or National Security. We may disclose your medical information for law enforcement purposes. For example, we may provide information about someone who is or is suspected to be a victim of a crime, to provide information about a crime at our office, or to report a crime that happened elsewhere. Further, we may disclose your medical information to federal officials for intelligence and national security activities authorized by law including to protect the President or other officials including foreign heads of state, to conduct investigations, or for military purposes.
Deceased Patients. We may release medical information to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs or, when requested, to facilitate organ, eye or tissue donation.
Research. Under certain circumstances, we may use and disclose your medical information for health related research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition.
Serious Threats to Health or Safety. We may use and disclose your medical information to prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
Incidental Disclosures. We may disclose your medical information if it is an unavoidable byproduct of conducting business, including receiving services from cleaning personnel and those maintaining or repairing equipment.
Business Associates. We may disclose your medical information to business associates who perform health care operations for us and who commit to respect the privacy of your health information.

Other uses and disclosures of your medical information not covered by this Notice will be made only with your written authorization. If you provide us such an authorization, you may revoke it, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your information for the reasons covered by the authorization.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights regarding the medical information that we maintain about you:

Confidential Communications. You have the right to request that we communicate with you in a particular manner. For instance, you may ask that we contact you at home rather than work. To request a type of communication, you must make a written request to the Compliance Officer listed on page one of this notice. We will accommodate reasonable requests.
Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your medical information for treatment (except in emergencies or when required by law), payment or health care operations. We are not required to agree to your request; if we do agree, we are bound by our agreement. You also have the right to request that we restrict our disclosure of your medical information to only certain individuals involved in your care. To request a restriction, you must make your request in writing to the Compliance Officer listed on page one.
Inspection and Copies. You have the right to see and copy your medical information. You must submit your request in writing to the Compliance Officer listed on page one. Our practice may charge a fee for the costs of copying and mailing your information. By law, our practice may deny your request to see and/or copy your information in certain limited circumstances; however, you may request a review of our denial. For information regarding such a review, contact the Compliance Officer listed on page one of this notice.
Amendment. If you feel that medical information we have about you is incorrect or incomplete, you may send us a written request to amend the information. The request must include a reason supporting your request and should be sent to the Compliance Officer listed on page one. We may deny your request if it is not in writing or does not include a reason. Further, we may deny your request if you ask us to amend information that is, in our opinion, accurate and complete, not part of the information kept by us, not part of the medical information which you would be permitted to see and copy, or it if was not created by us.
List of Disclosures. You have the right to request a list of disclosures our practice has made of your medical information for non-treatment, non-payment or non-operations purposes. Use of your medical information as part of the routine patient care in our practice is not required to be documented and, therefore, will not be on the list. Further, the list will not include disclosures made with your authorization, incidental disclosures or those required by law. In order to obtain a list of disclosures, you must submit your request in writing to the Compliance Officer listed on page one. All requests must state a time period (not to exceed six years) and may not include dates before March 21, 2005. You are entitled to one such list per year free of charge; additional lists may require payment.
Right to a Paper Copy of This Notice. You are entitled to receive additional copies of this notice of privacy practices at any time. To obtain a copy of this notice, please speak with the receptionist.
Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, write to the Compliance Officer listed on page one. This office will not penalize you in any way for submitting a request.

Acknowledgement of Receipt of this Notice. We will request that you sign a separate form or notice acknowledging you have received a copy of this Notice. If you choose not to sign, or are unable to sign, a staff member will sign their name, date and confirm the Notice was given to you.

Patient Financial Policy

TRANSCEND PHYSICAL THERAPY (TPT) is a freestanding physical therapy clinic, which means we are not affiliated with a hospital. TPT is dedicated to providing the best possible care and service to our patients in a cost effective manner. We regard our patient's understanding of financial responsibility as an essential element of quality care and treatment. In order to accomplish this, we depend upon prompt payment for the services we provide. To reduce any misunderstanding or confusion, we have adopted the following financial policy.

Payment options if you have insurance:
TPT has made prior arrangements with most insurance companies and plans to accept assignment of benefits. ***It is your responsibility to provide TPT with the most up-to-date insurance information. It is also your responsibility to know and understand your insurance coverage for Physical Therapy.*** Worker's compensation insurances should be aware and authorize patients beginning therapy and will usually have a claim number. Auto insurance should have a claim number and should be informed that you are having physical therapy. Many insurances have a limit on how many visits they will cover. It is best to check and be aware of your coverage. Please be advised that unreported changes in medical insurance could result in billing delays and errors. It is important to bring your current insurance cards with you to *each* appointment.

The following financial responsibilities apply:

A. You will need to pay your deductible, co-pay and any out-of-pocket portions at the time of service. ***Co-pays are due at the time of service.*** This is a requirement of your insurance plan. Unpaid co-pays will be reported to your carrier and may affect your insurance coverage. We reserve the right to charge a billing fee on co-pays when we have to prepare and send a statement.
B. In the event that the patient's health plan considers the service to be a "non-covered" benefit, you will be responsible for the charges at the time of service.
C. If TPT does not have a contract with your insurance company, you will be responsible for the charges at the time of service.
D. Failure to provide complete and accurate insurance information may result in patient responsibility for the entire bill.

Payment options if you have no insurance:
Payment is expected on the day that treatment is rendered unless *prior* arrangements have been made. You can pay by cash, check, MasterCard, or VISA. Alternative payment plans may be available. Please ask to speak with the Billing Manager prior to your appointment to discuss fees and payment plans.

Patient Appointments: We make every effort to schedule non-emergency appointments within a reasonable amount of time. Patients who have a serious problem often need to be seen on the same day. To accommodate all situations, we ask that patients call the office promptly if they are unable to keep an appointment or need to reschedule. The office reserves the right to charge for "no show" appointments.

Minors: The parent(s) or guardian(s) accompanying a minor are responsible for payment. Minors must be accompanied by a parent or legal guardian to be treated. Any exception requires the parent or legal guardian to provide TPT, prior to treatment, a signed "Authorization" to provide medical treatment.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the patient balance due for each visit. The total amount due from you will be summarized at the bottom of the statement. Unless we approve other arrangements in writing, the balance on your statement is due upon receipt.

Late Charges: Any balances not paid upon receipt of your statement will be assessed a monthly late charge at the rate of 1% of the outstanding adjusted balance of your account. The adjusted balance is determined by taking the patient balance owed at the end of the previous billing cycle and subtracting all payments and credits received during the present billing cycle. Neither the assessment or the collection of late charges will preclude TPT from taking steps to collect your account or even to refer it to a collection agency. **Late charges can be avoided by the timely payment of your account.**