COMBER PHYSICAL THERAPY FUSION CHIROPRACTIC

**New Location Mooretown Road Office**
201-B Bulifants Blvd., Williamsburg, VA
23188 P (757) 229-9740 F (757) 229-9741

**New Town Office**
5388 Discovery Park Blvd., Ste 100, Williamsburg, VA 23188
P (757) 903-4230 F (757) 903-4231

# Patient Reactivation Form

If you have previously been treated by Comber Physical Therapy & Fusion Chiropractic, LLC, please complete the following form so that we may keep your file up to date.

**In which location were you most recently seen?** New Town Lightfoot Fusion

**Please tell us your new diagnosis/complaint & your referring physician.**

_____

**Has your address or telephone number changed**? No Yes

If yes, new info: _____

**Has your insurance information changed in ANY way (new insurance company, different policy, new policy holder, etc)?** No Yes

If yes, new info: _____

Please make sure we take a copy of your new/updated insurance cards.

**Would you like to update or change your emergency contact information?** No Yes

If yes, new info: _____

**Have you received physical, occupational, or speech therapy from another facility OR via home health care with in this past year? If so, please explain which type, where and approximate dates:**

_____

_____

**Missed appointment Policy:**
I understand that appointments not kept or cancelled without 24 hours' notice prior to the scheduled appointment time, will be charged a $35 cancellation fee for all regular appointments, and a $50 cancellation fee for all specialty appointments, including Evaluations and Woman's & Men's Health. These charges cannot be billed to my insurance company and will be my responsibility. Missed appointment fees must be paid at the next scheduled appointment. A pattern of non-cancelled and missed appointments may result in cancellation of all future appointments and discharge from your practice. My credit card will be kept on file and will be charged in the event that these fees are not paid at the next appointment.

Patient/Guardian Name: _____ Signature: _____

Registration: _____ Date: _____

CAMBER PHYSICAL THERAPY
FUSION CHIROPRACTIC

# Health Intake Form

Patient Name: _____ DOB: _____

Reason for Therapy: _____

What was the date of the injury: _____

Is the reason for Therapy accident related: Yes No

If yes, please circle one: Auto Work Accident Other, please explain:

_____

What would you like to achieve by attending Therapy: _____

_____

Please rate your pain level:


What makes it better: _____

What makes it worse: _____

Describe your pain: _____

What treatments have you had for this injury: _____

Did they help: Yes No

Presently are you getting: better worse same

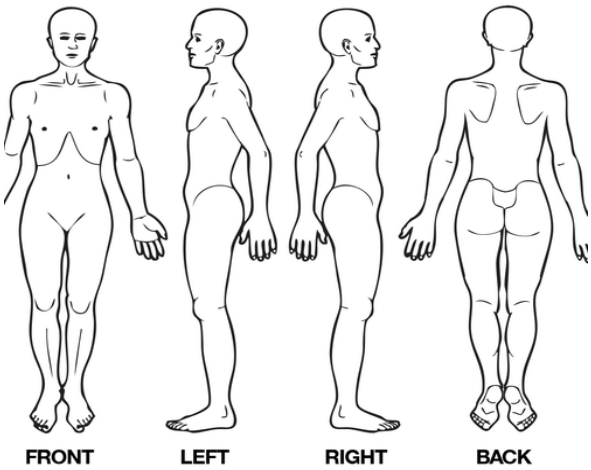
Have you had anything similar before: Yes No

If yes, when: _____

List any previous injuries: _____

_____

Mark the part of the body we are treating:



CAMBER PHYSICAL THERAPY
FUSION CHIROPRACTIC

Please circle any of the following health conditions that you currently or previously experienced:

| | | | | |
|---|---|---|---|---|
| Joint Replacement | Osteoporosis | Osteoarthritis | Dislocations | Shortness of Breath |
| Epilepsy | Fractures | Fainting | Hearing Loss | Difficulty Breathing |
| Disc Herniation | Swelling | Cancer | Diabetes | Bowel/Bladder Changes |
| High Blood Pressure | Headaches | Stroke | Pacemaker | Numbness/Tingling |
| Low Blood Pressure | Nausea | HIV/Aids | TIA (mini Stroke) | Decreased Coordination |
| Weight Loss | Seizures | Emphysema | Depression | Kidney/Bladder Problems |
| Hearing Loss | Chest Pain | Heart Disease | Fatigue | Tuberculosis |
| Anemia | Fever/ Chills | Chronic Cough | Hepatitis | Thyroid Problems |
| Head Injury | Hernia | Metal in Body | Smoking | Rheumatoid Arthritis |
| | | | | Anxiety |

Other: _____

Currently Pregnant: Yes No Communicable Disease: Yes No
If yes, Due Date: _____

Do you have any allergies: _____

At the present time would you say your health is: excellent very good fair poor

**Current List of Medications:**

| Medication | Dose | How often |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Surgeries (please also provide Dates):

_____

_____

Patient/Guardian Name: _____ Signature: _____

Registration: _____ Date: _____

## Financial Policy and Service Contract
## PLEASE READ CAREFULLY AND SIGN

It is my responsibility to know the limitations and restrictions of my insurance company regarding Physical Therapy and Chiropractic Care. I am responsible for paying my balance regardless of my insurance company's payments. Copays are expected to be paid at the time of service. If my insurance company does not cover Physical Therapy or Chiropractic Care and I choose to pay out of pocket for treatment, my balance is due at the time of my appointment.

I understand that laws and regulations at the Federal and State level, as well as conditions set forth by many insurance companies, place heavy and complex restrictions upon the office regarding the way they determine fees for office visits. There is very little leeway in these matters. As a result, my provider has no ability or authority to influence the amount I am charged for the services.

The fee charged for an office visit is determined by the level of complexity, which is not always known at the time of service. Per federal regulation, complexity is determined using a formula that takes into account both chronic and acute issues. My provider determines the level of complexity at the time of the evaluation.

I understand that Comber Physical Therapy and Fusion Chiropractic, LLC requires to keep a credit card on file. In the event my account is still outstanding after 30 days, I have been informed that my credit card will be charged. (This office policy is an effort to reduce cost related to our collections efforts, so we can offer you a more affordable healthcare overall.) A billing fee of $10 per month may also apply to delinquent balances, as well as a 33.33% charge for accounts sent to a collection agency and additional fees for accounts sent to small claims court. Checks returned without sufficient funds will be charged a $35 fee. Accounts more than 90 days old are subject to transfer to an outside collection agency, provided that I have not made special arrangements with Comber Physical Therapy and Fusion Chiropractic, LLC. Individuals who have come upon hard times are encouraged to work out a payment plan with the billing department.

I understand that if Comber Physical Therapy and Fusion Chiropractic, LLC is contracted with my insurance company, you will apply the contracted adjustment to my claims, reducing my cost. I understand that non-covered services, or services that may be considered not medically necessary by my insurance, are my responsibility and the contracted rate adjustment will not apply. I have received a copy of the notice informing me of my privacy rights and understand that my health information will be used for treatment, billing, and office preparation.

The Intake and Verification of Benefits Forms are only an explanation of coverage obtained from my insurance company and is not a guarantee of payment and coverage. I understand that Comber Physical Therapy and Fusion Chiropractic, LLC verifies my insurance benefits **as a courtesy**. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for all services rendered. Insurance companies do not pay all fees and may exclude certain services from coverage. I understand that it is my responsibility to know and understand my insurance plan.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initialed during or after the course of my treatments unless agreed to in writing by myself and a representative of Comber Physical Therapy and Fusion Chiropractic, LLC. I authorize payment be made by my insurance company directly to Comber Physical Therapy and Fusion Chiropractic, LLC for services, and to bill and release payment directly to Comber Physical Therapy and Fusion Chiropractic, LLC for any physical therapy or chiropractic care provided. If my current policy prohibits direct payment, I hereby instruct my insurance company to make out the check to me and mail it as follows:

For Physical Therapy: Comber Physical Therapy, LLC
5388 Discovery Park Blvd, Ste 200
Williamsburg, VA 23188

For Chiropractic: Fusion Chiropractic, LLC
5388 Discovery Park Blvd, Ste 200
Williamsburg, VA 23188

Patient Initials: _____

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A photocopy of this assignment shall be considered as effective and valid as the original. I authorize Comber Physical Therapy and Fusion Chiropractic, LLC to deposit checks received on my account for services rendered if they are made out in my name.

I understand that appointments not kept or cancelled without 24 hours' notice prior to the scheduled appointment time, will be charged a $35 cancellation fee for all regular appointments, and a $50 cancellation fee for all specialty appointments, including Evaluations and Woman's & Men's Health. These charges cannot be billed to my insurance company and will be my responsibility. Missed appointment fees must be paid at the next scheduled appointment. A pattern of non-cancelled and missed appointments may result in cancellation of all future appointments and discharge from your practice. My credit card will be kept on file and will be charged in the event that these fees are not paid at the next appointment.

I understand that verbal abuse or threatening behavior towards Comber Physical Therapy and Fusion Chiropractic, LLC providers and staff will not be tolerated. The practice reserves the right to discharge patients for any reason at any time, with or without notice. Discharges may occur for failure to meet my obligations under this document. In addition, because of quality considerations, the practice may discharge me for failure to comply with treatment plans as outlined by my practitioner.

**Credit Card on File**

Comber Physical Therapy and Fusion Chiropractic, LLC stores my credit card data using an encrypted and tokenized system at an offsite, secure vault that exceeds all HIPAA and PCI Data Security Standards. I can receive an email or paper receipt for any charges. Outstanding balances over 30 days will be charged to my card on file. I authorize Comber Physical Therapy and Fusion Chiropractic, LLC to debit the card on file for any patient responsibility, including but not limited to copays, remaining balance, payment plans and no shows/cancellation fees. I understand that I can update my card information on file in writing at any time. In fact, it is my responsibility to notify your office of any updates or changes to the credit card on file associated with this agreement as soon as possible.

Credit Card Number: _____

Name on the Card: _____

Expiration Date: _____

Security Code on the back of the card: _____

I have received this financial policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I authorize treatment and agree to pay all feed and charges for such treatment when it becomes due.

Patient/Guardian Name: _____ Signature: _____

Registration: _____ Date: _____

# General Policies

Thank you for choosing Comber Physical Therapy & Fusion Chiropractic, LLC for your rehabilitation needs. We appreciate that you have trusted us with your health care and are committed to providing you with the best patient care possible. Please carefully read through the following policy information.

Because healthcare benefits and coverage options have become increasingly complex, we have developed these policies to help you better understand your responsibilities as a patient and eliminate any unnecessary confusion. We will do our best to assist you with understanding your proposed treatment and in answering questions related to your care. Adhering to these policies will enable us to focus increased attention on providing quality care to our patients and run our clinics more efficiently.

If you have any questions in regard to the following information, please do not hesitate to ask.

**UPDATES:** It is important that we have your correct information on file. Please advise us anytime there is a change to your address, telephone number, or other contact information. If you are issued a new insurance card, please allow us a copy of it for your file as soon as possible. If your insurance changes or discontinues mid-treatment, please notify us immediately to avoid a delay in billing.

**PATIENT PRIVACY:** Comber Physical Therapy & Fusion Chiropractic, LLC is committed to protecting the privacy and security of our patients. During the course of treatment, it may be required to share information with other medical providers. We follow all Federal and State laws and regulations regarding private health information. Information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual as provided by law.

**INSURANCE COVERAGE:** As a courtesy to our patients, Comber Physical Therapy & Fusion Chiropractic, LLC is more than happy to directly bill your insurance for services rendered, but it is our policy that the patient is ultimately responsible for payment of the services received, should your insurance not cover. Furthermore, the patient is responsible for understanding their insurance coverage in relation to covered services.

Our clinic and therapists participate in the majority of regional health plan networks allowing you the benefit of "in-network" coverage. We make every attempt to verify your current insurance coverage. Verification of benefits is **NOT** a guarantee of payment. Information we collect includes effective dates, deductibles,
co-payments, and co-insurance amounts. We will try and review this information with you prior to the start of your treatment. In rare cases, we may not be able to obtain this information prior to your first visit. If you are unfamiliar with the terms used to explain your insurance benefits, please don't hesitate to ask us to clarify. Please remember that any changes made to your insurance policy, and the time of year billing is submitted, may affect coverage and reimbursement rates. We do not routinely research why an insurance carrier has not paid or why it paid less than anticipated.

Deductible and co-payments are part of your contractual agreement with your insurance company and it is our responsibility as participating providers to collect those fees. We have no authority over your deductible or co- payment amounts, nor can we change or waive those amounts. **Payments due are required to be paid at each visit.** If your insurance company reimburses more than the anticipated amounts and you have overpaid as a result, we will reimburse you the overpaid amount.

**AUTHORIZATION FOR TREATMENT & FINANCIAL AGREEMENT**
I hereby authorize Comber Physical Therapy & Fusion Chiropractic, LLC to perform on me (or below patient) the appropriate assessment and treatment procedures relating to my diagnosis and agree to pay all fees and charges for such treatment.

Patient Initials: _____

**CONSENT FOR TREATMENT IN A GROUP SETTING**
Comber Physical Therapy & Fusion Chiropractic, LLC in compliance with Federal HIPAA Regulations, is committed to protecting your health information and privacy. Our therapists and staff will be making every effort to ensure that your protected health information is kept private. However, due to the nature of the open setting of our therapy clinics, certain aspects of your treatment may be performed in the presence of other individuals. In some instances, it is possible that other patients, family members or friends, and our staff will overhear general information relating to your treatment, diagnosis, or benefits. We will do our best to ensure that any private or strictly confidential information is shared with you in a private area.

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**
I authorize Comber Physical Therapy & Fusion Chiropractic, LLC to release my health care information or other information pertinent to my case to any insurance company, adjuster, or attorney involved in my case, for the purpose of processing claims and securing payment of benefits.

**AUTHORIZATION TO FILE CLAIM**
Should my insurance company fail to comply with state laws and timely filing limits, I authorize Comber Physical Therapy & Fusion Chiropractic, LLC to contact the state insurance commissioner to file a claim on my behalf. By filing a claim, we can assist the state in identifying problematic situations and companies with a propensity for delaying or selectively reducing claim payment.

**MISSED APPOINTMENT POLICY:** If a patient schedules an appointment and fails to show up or cancels the appointment less than 24 hours in advance, they will be issued a $35 cancel fee. A $50.00 cancellation fee will be assessed to all specialized appointments, including Evaluations and Women's & Men's Health. A copy of our detailed missed appointment policy will be given to you at your first visit. **INITIAL:** _____

**RETURNED CHECKS:** A $35 non-sufficient funds fee will be charged for any checks returned to our office because of insufficient funds. If we receive a returned check, we will notify the patient or responsible party immediately and request that a cash payment be brought to one of our locations within 24 hours to repay the amount due in addition to the fee.

**BENEFICIARY/COLLECTION AGREEMENT:** If your health insurance company denies payment for any reason, you agree to be personally and fully responsible for payment of any non-covered services, deductibles, co-payments, or any other balance not paid by the insurance company for professional services that were rendered on each date of service. Should the account become delinquent after 90 days of non-payment, a collection process may be utilized at which time a collection fee of 33.3% will be assessed. Comber Physical Therapy and Fusion Chiropractic, LLC stores my credit card data using an encrypted and tokenized system at an offsite, secure vault that exceeds all HIPAA and PCI Data Security Standards. I can receive an email or paper receipt for any charges. Outstanding balances over 30 days will be charged to my card on file. I authorize Comber Physical Therapy and Fusion Chiropractic, LLC to debit the card on file for any patient responsibility, including but not limited to copays, remaining balance, payment plans and no shows/cancellation fees.
**INITIAL:** ____

Patient/Guardian Name: _____ Signature: _____

Registration: _____ Date: _____

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# Missed Appointment Policy

At Comber Physical Therapy and Fusion Chiropractic, LLC we would like to see you get the most of your physical therapy visits or chiropractic care. Your Physical Therapist or Chiropractor will provide you with your plan for care during the evaluation appointment and will inform you of the prescribed number of visits to help you meet your goals. A recent study has shown that patients who adhere to their plan of care increase their ability to have success from physical therapy and chiropractic care by 93%.

Even one missed visit can significantly decrease your success and result in a more chronic problem. We strongly stress the importance of keeping all your scheduled appointments to achieve your personal physical therapy and chiropractic goals.

Our schedule fills up quickly and certain time slots are not always available for patients who need them. For this reason, we require a minimum of 24 hours – or the Friday before a Monday – notice of cancellation, for any reason. When you call, we will assist you in rescheduling this appointment because getting you results is our main goal. As experts, we know that you will not get better if you do not attend your appointment. When you call to cancel an appointment, we expect that you will have other times available so we can reschedule you right away.

A fee of **$35** is charged for no shows and missed regular appointments. A fee of **$50** is charged for no shows and missed specialty appointments (incl. Evaluations and Women's & Men's Health). These fees will not be billed to the insurance and are your responsibility. A pattern of no shows and missed appointments may result in discharge from our practice. Please note, to avoid the $35 cancellation fee, you simply need to call the office and provide 24 hours' notice for any appointments you cannot attend. Calls the night before your appointment will not count as timely notice, so please call us during business hours.

For Worker's Compensation and Personal Injury patients, documentation of any missed appointments is forwarded to your case manager and primary physician. Excessive no shows and cancellations could jeopardize your claims with these insurances. While we understand that illness can strike at any time, repeated cancellations for illness without 24 hours' notice will not be an accepted excuse for untimely notice. While traffic can be unpredictable, we would like you to call us immediately if you are running late for your scheduled appointment, so we can be prepared for your late arrival.

Please be aware that if you are more than 15 minutes late for your appointment, you are missing the time that we have specifically scheduled for your care and 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 someone else. Chronically late patients will be asked to change their appointment time.

For all appointments we expect that you will arrive on time, dressed for your sessions, and ready to begin at your scheduled appointment time. At Comber Physical Therapy and Fusion Chiropractic, LLC we strive to return you to a healthy life. Thank you for your understanding and compliance with this policy.

Patient/Guardian Name: _____ Signature: _____

Registration: _____ Date: _____

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PHYSICAL THERAPY
FUSION CHIROPRACTIC

# Patient Insurance Verification Form

We always encourage that you check your benefits prior to starting therapy. Asking all of the questions on this form will help ensure that you receive the most accurate information possible. If you have any additional questions, please do not hesitate to ask us.

**Before you call your insurance company, have ready:**

Your Name (as on your card) _____ Birth Date _____

Subscriber's Name (spouse/parent) _____ Birth Date _____

ID Number _____ Group Number _____

**When you call your insurance company, say:**

"I am calling to verify my insurance for physical therapy/chiropractic in an **OFFICE** setting." Note the date/time and person you are speaking with (get a reference number) _____

If they ask where you are having your therapy: **Comber Physical Therapy & Fusion Chiropractic, LLC**.

NPI for Comber PT: 1689769473 Tax ID for Comber PT: 20-0143785

NPI for Fusion Chiro: 1265728307 Tax ID for Fusion Chiro: 45-2513478

**Ask the representative to tell you:**

What the effective Date of the plan is _____ If it runs on a calendar or plan year_____

What your current deductible is _____ How much of the deductible has been met _____

If you have a copay _____ How much the copay is _____

If you have a coinsurance _____ How much the coinsurance is _____

If the copay/coinsurance applies to your physical therapy/ chiropractic treatments _____

If there is a visit limit for physical therapy/ chiropractic care _____ How many have been used _____

If pre-certification or prior authorization for treatment is required _____

If you require a referral from a physician _____

Patient Name: _____ Date: _____