Fremont Therapy & Wellness
410 N Bell Street
Fremont, NE 68025

Patient Information Form & Consent to Treat

Full Name: _____ Preferred Name: _____

Gender: _____ Date of Birth: _____ Age: _____

Street/Mailing Address: _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Email: _____

Appointment Reminders - Preferred Method (circle): Text Message/ Email/ No Reminders

Emergency Contact: _____ Relationship: _____

Phone Number: _____

Referring Physician: _____ Location: _____

Primary Care Physician (if different): _____ Location: _____

How did you hear about us (circle)? Please specify, so we can say "Thank You!"

Family/Friend: _____ Google/Facebook Past Patient

Doctor (please list): _____ Insurance Network Work Comp

Consent to Treat/HIPAA Consent:
I consent to physical and/or occupational therapy care and treatment considered necessary and proper in evaluating or treating my physical condition as part of my plan of care.
CONSENT TO TREAT A MINOR: As parent and/or legal guardian, I authorize Fremont Therapy & Wellness to treat the minor patient named on this form while I am not present.

I acknowledge & agree that I have been provided the Health Insurance Portability and Accountability Act (HIPAA) information and the Notice of Privacy Practices. I hereby authorize the Designated Parties Below to request/receive any/all of my protected health information regarding my therapy treatments, accounts/payments and/or administrative operations related to my care. I understand that the identity of designated parties will be verified by photo ID before the release of any information.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

By signing below, I agree that all of the above information is correct, and that I authorize Fremont Therapy & Wellness to provide me with therapy services and to furnish my physician, insurance company or attorney information related to my treatment and care.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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Patient Medical History Form

Full Name: _____ Height: _____ Weight: _____

Type of Injury/Condition: _____ Date of Injury/Onset: _____

Type of Surgery/Procedure (if applicable): _____ Date of Surgery: _____

Referring Provider: _____ Primary Care Provider: _____

Have you seen anyone else for your current condition? (Circle all that apply)

Physician/MD	Chiropractor	Podiatrist	Orthopedic Surgeon
Dentist	Neurologist	Physical Therapist	Other:_____

Medical History: Have you ever had any of the following conditions/diagnoses? (Circle all that apply)

High Blood Pressure	Heart Condition	Stroke	Osteoporosis
Peripheral Neuropathy	Seizures/Epilepsy	Vision Problems	Diabetes: Type 1 / Type 2
Hearing Problems	Fainting/Dizziness	Emphysema/COPD	Frequent or Severe Headaches
Bladder/Bowel Problems	Arthritis	Asthma	Parkinson's
Multiple Sclerosis	Cancer: _____	Other: _____	

Have you had any falls in the past year?	YES	NO	If so, about how many? _____
Do you have a history of fractures?	YES	NO	Where? _____
Do you have any metal implants? (ex: pacemaker)	YES	NO	Where? _____
Do you smoke?	YES	NO	How much per day? _____
Do you exercise regularly?	YES	NO	How often? _____
Do you have any known allergies?	YES	NO	Please list: _____
Are you pregnant or think that you might be?	YES	NO	

Medications: Please list any medications (prescribed or over-the-counter) or supplements that you are currently taking:

_____

_____

Surgeries: Please list all surgeries including date/year: _____

_____

Diagnostic Tests: (Please circle any tests or procedures that have been done for your **current** condition.)

X-rays	MRI	CT Scan	Bone Scan
EMG	Blood Work	Bone Density	Ultrasound

Patient Signature: _____ Date:_____

Parent/Guardian Signature: _____Date: _____

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Payment and Insurance Policy

Financial Policy:
It is our policy to maintain your account on a current basis. Charges for treatment are due at the time the service is provided. We ask that you make copayments, co-insurance and payments towards deductibles at the time of each visit. It is the patient's responsibility to pay for any balances due in a timely manner for services rendered, regardless of insurance claims status.

Insurance Patients:
I hereby authorize Fremont Therapy & Wellness to furnish information to my insurance carrier(s) concerning this treatment and I hereby assign all payment for services rendered to Fremont Therapy & Wellness. If your insurance changes, please notify us as soon as possible.
Any patients who have not met their insurance deductible will require a $75 payment towards their deductible at time of each visit until their deductible is met. The remaining balance will be billed after the insurance claims process.

Self Pay Patients:
Physical Therapy and Occupational Therapy self pay cash rates: Initial Evaluation $125 and Follow-Up treatments $100 per visit.
Dry Needling Cash Rate: $45 per body region per treatment session for dry needling sessions only; $15 additional charge per treatment session while participating in therapy.
Shockwave (EPAT) Cash Rate: $250 package for evaluation with three shockwave treatments. Additional shockwave treatments are $75 per treatment for shockwave therapy only; $35 additional charge per treatment while participating in therapy.

High Balances:
If your account exceeds a balance of $350, we ask for you to pay as much of the balance as soon as possible via check, credit card, HSA account or arrange for a payment plan to be made.

Nonpayment of Balance:
Patients who have received three consecutive statements and have not made a payment towards their balance will receive a reminder letter and phone call to set up a payment plan. If no payment has been made by the fourth mailed statement, your account may be turned over to a collection agency.

Cancellation Policy
At Fremont Therapy & Wellness, we are passionate about goal setting and know that your recovery will be most successful when we work together. Our strategic 1-on-1 individualized treatment sessions with therapists and are designed to optimize your success while minimizing setbacks and regressions. Keeping all your regularly scheduled appointments is critical to not only the extent of your recovery, but also to the speed with which you will be able to return to your activities and passions.

Cancellation/No Show Policy
If you schedule an appointment and cancel less than 24 hours of your appointment time, this is considered a Late Cancellation and we reserve the right to charge you a $35 Cancellation Fee. If you schedule an appointment and do not come to your appointment, we reserve the right to charge you a $35 No-Show Fee. Cancellation and No-Show Fees are not billable to any form of insurance. In instances of non-compliance with your scheduled visits, we reserve the right to discontinue your care.

After three Late Cancels or No-Shows, you will be notified by our office regarding that any future visits will be removed from the schedule. If you are wanting to schedule an appointment, you will need to call the office that same day to see if there is availability for an appointment.

If you need to cancel a session, rescheduled appointments within the same treatment week will not be charged a late fee.
By signing below, you acknowledge that you have read, understand and agree to all the policies listed above.

Patient/Guardian Signature: _____ Date: _____