Center for Physical Therapy

Welcome to Physical Therapy!!

You have officially engaged in a personalized physical therapy program to address your physical concerns. Our staff are dedicated to assist you in meeting your goals, “one small victory at a time.”

Here is what to expect after your initial evaluation treatment:

1. 1. Follow up visits will last 1-2 hours depending on your specific condition. Allow time to complete your entire treatment each visit. Be aware your program will be modified as you progress and will change according to your personal needs.
2. Follow up visits will include a portion of dedicated time with your clinician (PT/PTA) for soft tissue mobilization, hands on treatment, dry needling or specialized exercises.
3. Follow up visits will also include and individually prescribed exercise routine which was created by your physical therapist. You will likely be assisted by a trained technician to flow through your exercises in a safe and efficient manner.
4. After receiving individual hands on and exercise based physical therapy, you may receive post treatment modalities such as ice, electric stimulation or ultrasound.

Our staff wear name and title badges at all times in order for you to identify us throughout your course of care. Our Physical Therapists will often “co-treat” their case load with a Physical Therapy Assistant. Physical Therapists and Physical Therapy Assistants are qualified health care professionals who both have had to take stringent license and certification examinations in order to provide physical therapy.

If at any time you are uncomfortable with your treatment, exercise or total experience, please speak up so we are able to address your concerns promptly and with your satisfaction in mind. We are here to listen and adjust our treatments to accommodate your specific needs. On that same note, if you feel you have received exceptional care, we would also appreciate your feedback.

Congratulations on your commitment to personal well-being. It is many time a challenging process; However you have taken the first step towards feeling better and achieving better health.

Move your Body, Live your Life!!!

Laura Markey

Laura Markey, PT, DPT, OCS
Fellow of the American Academy of Orthopedic Manual Physical Therapists.

Center for Physical Excellence, PC

Notice of Patient Information Practices

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

Center for Physical Excellence is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION: Center for Physical Excellence uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Center for Physical Excellence may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Center for Physical Excellence may also use or disclose your personal health information without prior authorization for auditing purposes and emergencies. We also provide information when required by law.

For any other situation, Center for Physical Excellence's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Center for Physical Excellence may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS: You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except specifically authorized by you, when required by law in emergency circumstances. Center for Physical Excellence will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS: If you are concerned that Center for Physical Excellence may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Center for Physical Excellence's health information practices or if you have a complaint, please contact the following person:

Laura Markey, PT
Center for Physical Excellence
3117 Stillwater Drive
Prescott, AZ 86305
Telephone: 928-442-0005 Fax: 928-442-0660

Center for Physical Excellence
building on small victories

What to expect in Physical Therapy

Physical Therapists are licensed professionals educated and trained to evaluate and treat a multitude of joint, muscle, and neurological problems. Physical Therapist Assistants are also educated health care professionals registered with the state to provide physical therapy.

Your first physical therapy visit will consist of an individualized examination by a licensed physical therapist. This examination will include a review of your medical history and measurements will be taken of your strength, mobility, range of motion, balance and potential causes of your discomfort. These findings will be reviewed with goals/expectations made between you and your physical therapist. A personalized treatment plan will be developed and will include education and hands-on contact by your physical therapist and/or physical therapist assistant.

Most clients are seen two to three times per week over one to two months. Each session lasts one to two hours. Treatments may include soft tissue and joint treatment, exercises, aquatic exercises and/or modalities such as ice, ultrasound, heat, and electrical stimulation. All treatments are designed individually with your specific goals in mind.

Physical Therapy sessions are focused on alleviating your pain and symptoms, as well as helping you get back to your normal daily routine. Physical Therapy should not be painful; however, on occasion you may experience some mild soreness from new exercises or treatment changes.

If you are referred for Aquatic Therapy, you will be asked a few important questions to assure your comfort in a water environment, as well as questions related to your health and safety. You will need to bring your own towel and bathing suit. We do have showers and lockers for your convenience.

If you are not participating in Aquatic Therapy, please wear loose and comfortable clothing. You will likely be moving and exercising in our well equipped exercise room after your hands-on treatment.

Each of our staff members has been chosen for their caring attitudes and their professional credentials. They will guide you through a pleasant and comfortable experience throughout the course of your care.

At the end of your care, you will be educated in self management strategies to prevent further episodes of pain/limitation. It is our priority that you are satisfied with your care and have reached the goals set between you and your physical therapist.

Center for Physical Excellence
Patient Information Consent Form

I have read and fully understand Center for Physical Excellence's **Notice of Information Practices**. I understand that Center for Physical Excellence may use or disclose my personal information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrated operations related to treatment or payment.

I also understand I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Center for Physical Excellence will consider requests for restriction on a case by case basis, but does not have to agree to request for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Center for Physical Excellence Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____

Printed Patient Name

_____ _____

Signature Date

_____ _____

CPE Staff Date

Center for Physical Excellence, PC
Financial Policy

FOR ALL PATIENTS: Please be assured that your health is our primary concern. The following office policies are outlined for your benefit in order to avoid possible areas of confusion. The office personnel are available to assist you if you have any questions.

Center for Physical Excellence, PC accepts assignment for Medicare. If your insurance plan has a co-payment, co-insurance or a deductible that has not been fulfilled, the payment of the co-payment, co-insurance and/or the amount of the remaining deductible is due at the time of service.

As a courtesy to you, this office will bill your insurance. We will also bill your Medicare secondary insurance if applicable. However, any and all charges not covered by your insurance(s) are due and payable without delay, unless prior arrangements are made with this office.

Our office will also verify the presence of insurance coverage on your primary insurance; however, you are responsible for knowing the benefits and restrictions of your insurance policy. At your request, we will assist you with obtaining pre-certification or pre-authorization required by your insurance.

Any special requirements for services, pre-certification for services, or pre-authorization are ultimately your responsibility.

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I have read and understand the above Financial Policy and hereby acknowledge that any and all medical bills, collection fees on my account, or lawyer's fees incurred due to my delinquent payments are my personal responsibility.

I hereby authorize Center for Physical Excellence to perform rehabilitation services to myself/child and authorize them to release my therapy records (including my evaluations, treatment records and progress notes to my physician, insurance carrier, and/or other named institutions).

I authorize payments of medical benefits to Center for Physical Excellence for any medical care rendered to myself or to my dependents. I understand that I am responsible for any amount not covered by my insurance.

I acknowledge all of my patient information is complete and true. I also understand that overdue balances may incur additional charges. I will bear the cost of collection and/or court costs/legal fees should this be required.

Signature: _____ Date: _____

CPE Staff: _____ Date: _____

Center for Physical Excellence Cancellation and No-Show Appointment Policy

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic, because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

- We require **48 hours** notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible. (In some cases, this may not work since some forms of treatment do not work well if given two sequential days.)
- There will be a **$100.00** charge for appointment cancellation without 48 hour notice. This charge will not be covered by insurance, but will have to be paid by you personally.
- For **Workers Compensation** patients, documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.
- You may need to see a therapist other than the one who normally treats you if you re-arrange your appointment. All of our therapists are experienced professionals, and they study your patient chart, so you will be in good hands.
- Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. Either condition can seem to be a reason not to come in: a) you're feeling worse and think the treatment is not working or, b) you're feeling better and it's a great day for hiking. Neither of these conditions is legitimate as a reason not to come. If you're in pain, come in and get it fixed. If you're out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem, educate you so you won't re-injure yourself, etc.

When you do not show as scheduled, three people are hurt: you because you don't get the treatment you need as prescribed by the doctor and /or PT; the therapist who now has a space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice.

If you do not show for three appointments during the course of your therapy or if you fail to return repeated telephone calls from our staff; your referring physician or case manager will be notified. All remaining appointments will subsequently be removed from your schedule.

Please co-operate with us in this regard. We're looking forward to working with you.

I have reviewed this policy with a member of CPE staff. I understand and agree to abide by this policy.

_____ _____

Patient Signature **Date**

_____ _____

CPE Staff Signature **Date**

Medicare Out-Patient Physical Therapy Services

As of January 1, 2021, Medicare has reinstated the cap on out-patient physical therapy services provided in a private practice setting. The yearly maximum as of January 2021 is **$2,110.00** per calendar year (an increase from the previous cap of $2080.00) for combined physical therapy and speech-language pathology services. Medicare will pay 80% of their acceptable charges after your deductible has been met.

Your secondary or supplemental insurance carrier (if applicable) will then pay a portion of the remaining 20%; depending upon your individual plan benefits. As a courtesy to you, Center for Physical Excellence, PC will bill your secondary carrier for the remaining 20% of Medicare allowable charges. Any balance remaining after secondary reimbursement will be your responsibility.

In order for physical therapy services to be covered by Medicare B:

1. It must be demonstrated that the judgment, skills, and knowledge of a qualified physical therapist are necessary for the patient to progress, and
2. There must be an expectation that the patient will improve significantly in a reasonable and generally predictable period of time.

Medicare may pay for infrequent re-evaluation visits but will NOT pay for maintenance level therapy, modalities, or exercises that can be performed at home.

After completing your evaluation or re-evaluation; if your physical therapist believes that additional physical therapy services would not meet the requirements for Medicare reimbursement, it is then your decision with the referring physician's approval to continue physical therapy services. At that time you will have the option of receiving physical therapy in a hospital based setting or sign an Advanced Beneficiary Notice and assume full financial responsibility for the remainder of your care to continue at Center for Physical Excellence.

Please sign below to indicate you have read and understand this notice and authorize Center for Physical Excellence, PC to hold you financially responsible for all physical therapy charges incurred after your physical therapist deems services to be non reimbursable by Medicare.

Signature: _____ Date: _____

CPE Staff: _____ Date: _____

Physical Therapy & Home Health Care

Medicare will not cover outpatient physical therapy costs if you are currently receiving any home health care services. if you have started a physical therapy regime and THEN begin using home health care services, Medicare will deny payment for your physical therapy.

By signing this, I understand Medicare's coverage of physical therapy services will be denied if I am under the care of a Home Health Care Agency. I am acknowledging that I am not receiving home health care services of any kind.

During the course of my physical therapy treatment I will inform Center for Physical Excellence prior to any home health care services being received or initiated.

Signature _____ Date: _____

CPE Staff _____ Date: _____

General Health Information

Height: _____ Weight: _____

Do you drink enough water daily? Yes / No / I don't know

Do you smoke? Yes / No packs/day: _____

Are you pregnant? Yes / No Weeks: _____

How many times a week do you exercise? _____

Are you satisfied with your body weight? Yes / No

Do you believe you eat healthy food? Yes / No

Have you fallen in the past year? Yes / No
If so, how many times _____

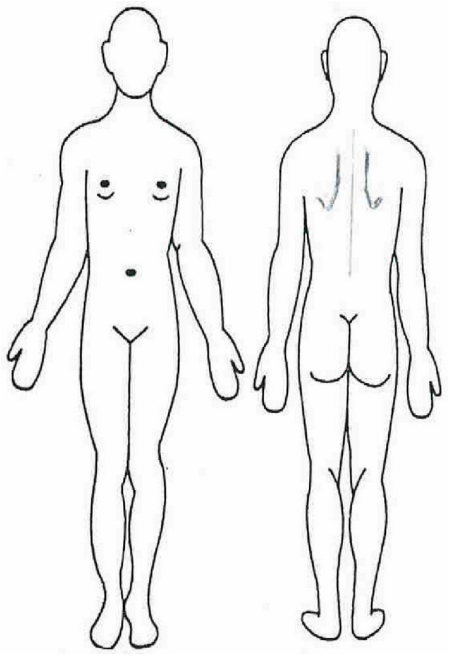
What is your current stress level on a 0-10 scale: _____

Hobbies/Recreation:

Other medical/surgical history:

Concerns:

Please mark the body diagram with the following symbols:
"X" any areas of pain "^" any areas of altered sensation



Do you experience... *(please check all that apply)*

- Weakness in the lower extremities
- Weakness in the upper extremities
- Reduced control of bowel or bladder
- Pain with coughing or sneezing
- Collapse / giving way of leg
- Drop of foot Right Left (circle one)

Rate your current level of pain on the scale below:

0 1 2 3 4 5 6 7 8 9 10
none worst ever

Fluctuation of pain over the past week:
Best: _____ Worst: _____

Emergency Contact: _____ Telephone: _____

Your Employer: _____ Telephone: _____

Printed Name: _____
Signature: _____ Date: _____

EASI Questionnaire	Yes	No	Do not wish to answer
1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?			
2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?			
3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened			
4. Has anyone tried to force you to sign papers or to use your money against your will?			
5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?			

Patient Health Questionnaire (PHQ-9)				
Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly every day
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, hopeless	0	1	2	3
Trouble falling asleep or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself – or that you are a failure or have let yourself or family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual.	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself.	0	1	2	3
(For healthcare professional) Add Columns:				
Total:				

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	_____
	Somewhat difficult	_____
	Very Difficult	_____
	Extremely Difficult	

Printed Name: _____

Signature: _____ **Date:** _____

Medication List

My Name: _____ My Phone #: _____

My Birth Date: _____ My Email: _____

MEDICATION brand, generic name, dose	HOW OFTEN ?	HOW TAKEN ?	REASON FOR TAKING	NOTES
Example: equate, Ibuprofin, 200mg	2x/day	by mouth, with water	NSAID, pain killer, fever reducer	

My Allergies

CPE Staff

Center for Physical Excellence Ph: (928) 442-0005 Fax: (928) 442-0660