STEP UP Physical Therapy, PLLC
Senior **T**argeted **E**xercise and **P**hysical therapy
Phone 303 909-9393 Fax 303 738-5544 www.stepuppt.com

New Patient Agreement

Patient Name: _____

You may pay cash for STEP UP Physical and Occupational Therapy services.

Physical or Occupational Therapy Evaluation: $150
Physical or Occupational Therapy Treatment Session: $110
Personal Training Session: $110

Please read the following information:

- Payment is due at time of service for any cash pay service.
- We accept cash or check (make payable to: STEP UP Physical Therapy, PLLC)
- Cancellation/appointment policy: Unless you cancel at least 24 hours in advance, our policy is to charge $50.00 per missed appointment. This will allow us to fill your appointment slot with someone who may need care urgently.

By signing below I understand and agree to this Financial Policy and acknowledge I have read the notice of privacy practices.

X_____ Date_____

Permission to Treat
I authorize the licensed physical and/or occupational therapists at STEP UP Physical Therapy to provide me with evaluation and treatment.

X_____ Date_____

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New Patient Agreement

Patient Name: _____

We are a Medicare Provider. Your insurance benefit is described below:
Outpatient Physical Therapy Benefit Threshold (2024): $2,330 (~18 visits). You may qualify for coverage beyond that amount.
Outpatient Occupational Therapy Benefit Threshold (2024): $2,330 (~18 visits). You may qualify for coverage beyond that amount.
Annual Deductible (for 2023): $240
Coinsurance: Medicare considers 80% of charges. Secondary insurance or patient responsibility 20%.
Copayment: None
Notes: You must not currently be receiving Medicare covered home health care in order for Medicare to pay for this outpatient service. This includes home health nursing, home health aide, home health therapy (speech, occupational, physical).
Billing policy for therapy: We will bill Medicare and your secondary/supplemental plan for services.

Important: This is not a guarantee of payment for services. This is strictly a description of your benefits for outpatient physical and/or occupational therapy. If you do not feel this benefit is correct, please contact your insurance company. Ultimately, you are responsible for ANY amount not covered by your insurance company.

Please read the following information:

- Your insurance policy is a contract between you and your insurance company. We will bill your insurance company on your behalf. **Any amount not covered or denied by your insurance company is your responsibility. If your insurance company has not made payment on your account within 90 days, you must pay your account in full or make arrangements for a payment plan. You may then contact your insurance company for reimbursement. Should your account be sent to collections, we reserve the right to charge interest on the overdue balance in the amount of 21% as approved by law.**

- We cannot bill your insurance company unless you give us your current insurance information. Please notify us of any changes. In the event your insurance company changes and we are not a participating provider, you may be responsible for these charges.

- Payment is due at time of service for any cash pay service. Once your insurance company has processed your claim, any remaining balance is your responsibility to be paid within 30 days of billing date. In the event that your insurance policy changes and we are not a participating provider, you may be responsible for these charges.

- Cancellation/appointment policy: Unless you cancel at least 24 hours in advance, our policy is to charge $50.00 per missed appointment. This will allow us to fill your appointment slot with someone who may need care urgently. Your insurance company will not cover missed appointment fees.

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Permission to Treat

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X_____ Date_____

Assignment to Pay Benefits and Medical Information Release

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment (Physical and Occupational Therapists of STEP UP Physical Therapy, PLLC).

X_____ Date_____

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New Patient Agreement

Patient Name: _____

We accept insurance with out of network benefits.
%insurance coverage/ % patient responsibility: Dependent on plan: _____
Deductible: Dependent on plan: _____
Copayment: Dependent on plan: _____
Billing policy for therapy: We will bill your insurance plan for services rendered.

Important: This is not a guarantee of payment for services. This is strictly a description of your benefits for outpatient physical and/or occupational therapy. If you do not feel this benefit is correct, please contact your insurance company. Ultimately, you are responsible for ANY amount not covered by your insurance company.

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X_____ Date_____

STEP UP Physical Therapy

AGENCY DISCLOSURE NOTICE

Agency Type: ☐ Home Care Placement ☐ Home Health Care ☐ Personal Care or Non-Medical

Each home care agency or home care placement agency is required to provide the consumer information as to the responsibilities of the agency, the home care worker, and the consumer regarding the employment and duties of each.

☐ Agency is the employer of record for all staff providing direct care services and is responsible for all items listed below.

☐ Responsibilities are delineated below:

Consumer	Worker	Agency	
		X	Employer of the home care worker.
		X	Supervision of the home care worker.
		X	Scheduling of the home care worker.
		X	Assignment of duties to the home care worker.
		X	Hiring, firing and discipline of the home care worker.
		X	Provision of supplies or materials for use in providing services to the consumer.
		X	Training and ensuring qualifications that meet the needs of the consumer.
		X	Liability for the home care worker while in the consumer's home.
Consumer	Worker	Agency	Payment of:
		X	Wages to the home care worker.
		X	Employment taxes for the Home Care Worker.
		X	Social Security taxes for the Home Care Worker.
		X	Unemployment insurance for the Home Care Worker.
		X	General liability insurance for the Home Care Worker.
		X	Worker's Compensation for the Home Care Worker.
		X	Bond Insurance (if provided).

The above information and areas of responsibility have been explained and any questions have been answered in regard to responsibilities held by the consumer, the home care worker and the agency.

Consumer or Authorized Representative:_____ Date:_____

Home Care Worker : _____ Discipline: _____ Date:_____
(if not employee or contractor to the agency where the agency holds full responsibility)

Agency Representative: _____ Title: _____ Date:_____

Printed Name of Consumer: _____ Start of Care Date: _____

Name: _____ Date: _____

Personal Emergency/Disaster Plan

A personal disaster plan is important to have in place before an emergency or disaster occurs. Agency personnel will help you develop a plan. Additionally, you will be evaluated upon admission to determine your service and evacuation needs in the event of a disaster.

The reality of a disaster situation is that you will likely not have access to everyday conveniences. To plan in advance, think through the details of your everyday life. If there are people who assist you on a daily basis, list who they are and how you will contact them in an emergency. Create your own personal support network by identifying others who will help you in an emergency. Think about what modes of transportation you use and what alternative modes could serve as backups. If you require handicap accessible transportation, be sure your alternatives are also accessible. Make a plan and write it down. Keep a copy of your plan in your emergency supply kits and a list of important information and contacts in your wallet. Share your plan with your family, friends, care providers, and others in your personal support network.

Emergency Contact Information

	Phone	Address
Police/Fire/EMS	911	n/a
Local Red Cross: Mile High Chapter	303-722-7474	444 Sherman St. Denver, CO 80203
Physician:		
Pharmacy:		

Relatives

Name	Home Phone	Cell Phone

Friends/Neighbors

Name	Hone Phone	Cell Phone

My Medical Information

Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Age: _____ DOB: _____

Health Insurance Plan: _____ Blood Type: _____

I have a DNR: (circle one) Yes No

Medical Conditions: _____

_____

_____

Allergies: _____

_____

Special Equipment I need: _____

_____

My DME Supplier is: _____

Phone: _____

Communication/cognitive Difficulties: _____

Disaster Preparedness Checklist

____ Make a list of all medicines including over the counter medicines

____ Have a list of telephone numbers for emergency. Be sure at least one of them is in another area. This should include family, neighbors, physicians.

____ Have a list of medical conditions, along with a list of any medical treatments required

____ Put together a "go bag" for situations when you might have to leave home for safety. This should include a change of clothes, medicines, medical equipment and supplies, food, water, toilet paper, flashlight (with extra batteries), cash, house keys, and cell phone charger.

____ Label all medical equipment with your name

____ Have supplies necessary if forced to stay home due to a disaster (food, water, first aid kit, medications, extra medical supplies if needed)

____ Notify your utility company of priority need for utilities if special medical equipment is being utilized such as oxygen

____ Locate nearest emergency shelter

____ Have important identification and insurance information easily accessible. Make copies and keep with other lists in plastic bags

____ Make sign that reads "Evacuated" to leave on door in case of evacuation

* All lists should be in plastic bags; lists and "go bag" should be easily accessible

* If you take medicine or use a medical treatment on a daily basis, be sure you have what you need on hand to make it on your own for at least one week. You should also keep a copy of your prescriptions as well as dosage or treatment information. If it is not possible to have a week-long supply of medicines and medical supplies, keep as much as possible and talk to your pharmacist or doctor about what else you should do to prepare.

Emergency Supply Kit

Basic Supplies:

Think first about the basics for survival – food, water, clean air, and any life sustaining items you require

1. **Water**
    a. In a disaster, water supplies may be cut off or contaminated. Store enough water for everyone in your family to last for at least 3 days
    b. Store one gallon of water, per person, per day. This amount will be adequate for general drinking purposes
    c. Three gallons per person, per day will give you enough to cook and for limited personal hygiene. Do not forget to plan for your pets
    d. Children, nursing mothers, and sick people may need more water
    e. During warmer months, more water may be necessary
    f. Store water in food grade plastic containers (such as clean 2-liter soft drink bottles or heavy duty, reusable plastic water containers)
    g. Store in a cool, dark place
    h. Replace water every 6 months and label container with replacement date
    i. If you buy bottled water:
        i. Keep water in its original container; don't re-store a bottle once it's been opened
        ii. Replace water at least once per year
        iii. Label bottles with their replacement date
    j. Treating water after a disaster:
        i. If you run out of stored drinking water, stain and treat water from your water heater or the toilet reserve tank (except if you use toilet tank cleaners); you cannot drink swimming pool or spa water, but you can use it for flushing toilets or washing
            1. Strain any large particles of dirt by pouring water through a couple of layers of paper towels or clean cloth
        ii. Next, purify water one of two ways:
            1. Boil – bring to a rolling boil and maintain for 3-5 minutes. To improve taste, pour it back and forth between two clean containers to add oxygen back
            2. Disinfect – If the water is clear, add 8 drops of bleach per gallon. If it is cloudy, add 16 drops. Shake or stir, then let stand 30 minutes. A slight chlorine taste and smell is normal.

2. **Food**
    a. When a disaster occurs, you might not have access to food and/or electricity for days, or even weeks. Store enough food to provide for your family for at least 3 days
    b. Store food items that are familiar (rather than buying special emergency food). Consider any dietary restrictions you may have.
    c. Ideal foods are shelf-stable (no refrigeration required), low in salt, and do not require cooking (e.g. canned fruit, canned vegetables, peanut butter, jam, low sodium crackers, cookies, cereals, nuts, dried fruit, canned soup or meats, juices, and non-fat dry milk). Don't forget Ensure if you use it.
    d. Label a rotation date on any food container that doesn't already have an expiration date on the package
        i. Most canned foods can be safely stored for at least 18 months
        ii. Dry goods (e.g. cereal, crackers, cookies, dried milk, dried fruit) must be used within 6 months
    e. Include baby food and formula or other diet items for infants or seniors
    f. Store the food in airtight, pest-resistant containers in a cool, dark place
    g. Include a manual can opener, food utensils, paper plates, plastic cups, and paper towels
    h. After a power outage, refrigerated food will stay cold longer if you keep the door closed
        i. Food should generally be consumed within 4 hours
        ii. Food in the freezer will normally remain safe for 2 days

3. **General Items**
    a. Dust mask to help filter contaminated air
    b. Plastic sheeting and duct tape to shelter in place
    c. Moist towelettes, garbage bags, and plastic ties for personal sanitation
    d. Wrench or pliers to turn off utilities
    e. Local maps
    f. Battery-powered or hank crank radio and a NOAA Weather Radio with tone alert and extra batteries for both
    g. Flashlight and extra batteries
    h. Whistle, horn, bell, etc. to signal for help
    i. First aid kit
    j. Prescription medications you take every day. You should periodically rotate medications to account for expiration dates

4. **Additional Items to Consider for your Emergency Supply Kit**
    a. Glasses
    b. Extra batteries for oxygen, breathing devices, hearing aides, wheelchairs, radios
    c. Pet foot, extra water or supplies for your pet or service animal
    d. Copies of important documents insurance policies and bank accounts in waterproof, portable container (plastic bags)
    e. Cash
    f. Sleeping bag or warm blanket for each person
    g. Fire extinguisher
    h. Matches in waterproof container

Storing Supplies:

Purchasing small amount of supplies each week is easy on the budget. Choose an appropriate and accessible place to store supplies. Many people use either a large plastic garbage can or a number of small ones.

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Personal Information and Medical History

Name: _____ Date: _____ Age: _____ Date of Birth: _____

Height: _____ Weight: _____

Address: _____ City/State/Zip Code: _____

Home Phone #: _____ Alternate (circle: Cell or Work) _____ Email: _____

Emergency Contact (Name and Phone #): _____

Referring Physician: _____ Primary Care MD(if different): _____

Primary Insurance: _____ ID#/Group#: _____

Secondary Insurance: _____ ID#/Group#: _____

Reason for Physical Therapy: _____

How did this problem start? _____

Date of Onset: _____ Pain Intensity (0 to 10, where 0=none, 10=emergency): _____/10____

Have you had or are you scheduled for any diagnostic tests (X-ray, MRI, etc.)? _____
_____

Have you received/ are you receiving any treatment for this problem (acupuncture, chiropractic, home health)?
_____

Surgeries or past injuries (and dates): _____
_____

Current Medications: _____
_____
_____

What activities are you limited in because of your problem? _____
_____

What are your goals with Therapy? _____
_____

Do you drink alcoholic beverages (circle one)? YES / NO If yes, how many per week? _____

Do you or have you smoked (circle one)? YES / NO If yes, how much? _____ Date quit_____

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Have you or an immediate Family Member experienced any of the following problems?	YOU		FAMILY	
	YES	NO	YES	NO
Bowel and Bladder Changes, or loss of control				
Numbness or Tingling				
Headaches				
Angina or chest pain				
Heart or Cardiac problems/ disease				
High Blood Pressure				
Shortness of Breath				
Unexplained Weight Loss				
Depression				
Anxiety				
Other Psychological Problems				
Cancer				
Diabetes				
Osteoporosis/Osteopenia				
Osteoarthritis				
Rheumatoid Arthritis				
Asthma / Hay fever				
Allergies				
Epilepsy / Seizures				
Stroke				
Parkinson's disease				
Multiple Sclerosis				
Tuberculosis				
Hepatitis A, B, or C				

Self related health question:
At the present time, would you say that your health is: excellent, very good, fair, or poor? _____

Is there anything else that you would like to share with us (circle one)? YES / NO If yes, explain _____
_____
_____

Written Notice of Home Care Consumer Rights

As a consumer of home care and services you are entitled to receive notification of the following rights both orally and in writing. **You have the right to exercise the following rights without retribution or retaliation from agency staff:**

1. Receive written information concerning the agency's policies on advance directives, including a description of applicable state law;

2. Receive information about the care and services to be furnished, the disciplines that will furnish care, the frequency of proposed visits in advance and receive information about any changes in the care and services to be furnished;

3. Receive care and services from the agency without discrimination based upon personal, cultural or ethnic preference, disabilities or whether you have formulated an advance directive;

4. Authorize a representative to exercise your rights as a consumer of home care;

5. Be informed of the full name, licensure status, staff position and employer of all persons supplying, staffing or supervising the care and services you receive;

6. Be informed and participate in planning care and services and receive care and services from staff who are properly trained and competent to perform their duties;

7. Refuse treatment within the confines of the law and be informed of the consequences of such action;

8. Participate in experimental research only upon your voluntary written consent;

9. Have you and your property to be treated with respect and be free from neglect, financial exploitation, verbal, physical and psychological abuse including humiliation, intimidation or punishment;

10. Be free from involuntary confinement, and from physical or chemical restraints;

11. Be ensured of the confidentiality of all of your records, communications, and personal information and to be informed of the agency's policies and procedures regarding disclosure of clinical information and records;

12. Express complaints verbally or in writing about services or care that is or is not furnished, or about the lack of respect for your person or property by anyone who is furnishing services on behalf of the agency.

If you believe your rights have been violated you may contact the agency directly:

STEP UP Physical Therapy
8033 S Race Way, Centennial, CO 80122
Contact Person: Katherine Deines, PT, DPT, NCS, owner and administrator: 303-909-6007

You may also file a complaint with the Health Facilities and Emergency Medical Services Division of the Colorado Department of Public Health and Environment via mail or telephone:
4300 Cherry Creek Drive South
Denver, CO 80246
303-692-2910 or 1-800-842-8826

I attest to verbal and written receipt of the aforementioned notice of rights:

_____ _____
Consumer or Authorized Representative Signature Date

_____ _____
Agency Representative Signature Date