FINANCIAL POLICY

Thank you for choosing **Linx Physical Therapy & Wellness** as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered as a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.
All patients must complete our Information and Insurance form before seeing the therapist.

FULL PAYMENT IS DUE AT TIME OF SERVICE.

WE ACCEPT **Cash, Checks, Visa, MasterCard**

Regarding Insurance

Out of Network Benefits

We may accept assignment of insurance benefits. However, we do require you pay what is not covered by your insurance at the time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

In Network Benefits

Regarding Insurance Plans where we are a participating provider. All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Attorney & Liability

I understand that monthly statements will be sent directly to my attorney. I understand and agree that I am ultimately responsible for any and all charges incurred for treatment. Should my attorney fail to make payment directly to LINX Physical Therapy & Wellness Center upon settlement of the case or no settlement is obtained. I understand and agree that I am responsible for any balance that is outstanding with LINX Physical Therapy & Wellness Center. I will notify LINX Physical Therapy & Wellness Center of any changes in my case, such as obtaining a new attorney; case is lost or dismissed, etc.

Adult Patients

Adult patients are responsible for full payment at time of service.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard, or payment by cash or check at time of service has been verified.

Missed appointments

Unless canceled at least 24 hours in advance, our policy is to charge $25.00 for missed appointments. Please help us serve you better by keeping scheduled appointments.

Interest

We reserve the right to charge interest in the amount of ___0.00___% as provide by state law.

I have read the financial agreement and understand that I am ultimately responsible for debt incurred for treatment at LINX Physical Therapy & Wellness Center. My insurance benefits have been explained to me and I fully understand what my insurance has verified that they will pay. I also understand verification of benefits is not a guarantee of payment and I am ultimately responsible for any balance with LINX Physical Therapy & Wellness Center.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy:

X ____ Date ____

Signature of Patient or Responsible Party

X ____ Date ____

Signature of Witness

Linx Physical Therapy & Wellness Center
Patient Information

Date:_________________________ **SS#:________________________**

First Name:_____________________________________ MI:___________ Last Name:__________________________________

Mailing Address:______________________________________ Physical Address:____

City:____ State:____________________ Zip:________________

Home Phone #:____ Cell Phone #:____

Sex: Male Female Martial Status: S M W D Date of Birth:____________________
(month/day/year)

Was condition related to: ( ) Employment ( ) Auto Accident ( ) Other__________________________________

Date condition / Accident began:_______________ Body site of condition / injury:________________ Date of surgery:________________

Body Site of Surgery:______________________________ Referring Physician:____

Next Appointment:_____________________________ Email address:____

Family Physician:________________________________Circle one: SMOKER or NON-SMOKER

Employer:____ Employer Phone #:___________________________________

Spouse's Name:____ Spouse's SS#:_________________________________

Spouse's Employer:____ Spouse's Employer Phone #:_______________________

Please tell us how you heard about Linx Physical Therapy & Wellness Center? ____

Please provide contact information where someone can be reached in case of emergency while patient is receiving therapy

Home Phone #:___________________________ Cell Phone #:________________________

Name:____ Relationship:______________________________

Guarantor Information
(Who is responsible for bill if different from patient)

Name:_______________________________________ Address:____

City:____ State:______________ Zip:_______________________________________

Relationship to Patient:_____________________ SS #:__________________________ Date of Birth:______________________
(month/day/year)

I, _______________________________________, authorize Linx Physical Therapy & Wellness Center to provide physical therapy, occupational therapy and speech therapy treatments as needed. I also authorize the release of all medical records to my insurance company, attorney, referring physician, rehabilitation nurse or worker's compensation insurance. I also authorize payments for services rendered to be made directly to Linx Physical Therapy & Wellness Center. I do hereby acknowledge my debt with Linx Physical Therapy & Wellness Center and that I am ultimately responsible for that debt. Also, the above medical information is correct to the best of my knowledge.

____ _________________________
Signature of Patient or Guardian **Date**

ARE YOU CURRENTLY RECEIVING HOME HEALTH SERVICES? ( ) YES ( ) NO

Linx Physical Therapy & Wellness Center
Medication Form

Please list all medications, prescribed and over the counter, you are taking. This includes any supplements and vitamins.

Medication	Dose	Frequency	Reason for Taking

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.

LINX PHYSICAL THERAPY & WELLNESS CENTER'S LEGAL DUTY

LINX Physical Therapy & Wellness Center 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

LINX Physical Therapy & Wellness Center uses your personal health information primarily for treatment; obtaining payment for treatment; conduction internal administrative activities and evaluation the quality of care that we provide. For example, LINX Physical Therapy & Wellness Center 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.

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

In any other situation, LINX Physical Therapy & Wellness Center'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.

LINX Physical Therapy & Wellness Center may change its policy at any time. When changes are made, a new Notice 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 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 health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. LINX Physical Therapy & Wellness Center will consider all such request on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that LINX Physical Therapy & Wellness Center may have violated your privacy right or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice owner 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 LINX Physical Therapy & Wellness Center's health information practices or if you have a complaint, please contact the following person:

LINX Physical Therapy & Wellness Center
Marcy Linxwiler, PT/Owner
25550 Juban Road, Suite B
Denham Springs, La 70726
225-665-8600

NOTICE OF INFORMATION DISCLOSURE CONSENT FORM

I have read and fully understand LINX Physical Therapy & Wellness Center's Notice of Information disclosure. I understand that LINX Physical Therapy & Wellness Center may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment and payment. I understand that 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 LINX Physical Therapy & Wellness Center will consider request 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 LINX Physical Therapy & Wellness Center's Notice of Information Disclosure. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

X _________________________________ Date _________________________________
Print Name

X ____________________________________
Signature of Patient or Responsible Party

Patient Easy Pay Consent Form

Patient Name:_________________________________

Please Check One:

____ I authorize Linx Physical Therapy & Wellness Center to charge my credit card or bank card for my co pay portion of $______ per visit on last day of services rendered that week.

____ I authorize Linx Physical Therapy & Wellness Center to charge my credit card or bank card in the amount of $______ to be applied to my deductible, every Friday, until my balance is paid in full.

____ I decline the easy pay option and guarantee payment upon services being rendered.

I understand that this form is valid for one year unless I cancel the authorization through a written notice.

_________________________________ ____________
Signature Date

Patient Name	Credit Card Account # Expiration Date:
Billing Address	Exact Name on Credit Card
Circle One: Visa MasterCard	Card Holder Signature

Trigger Point Dry Needling (TDN) Consent Form

Trigger Point Dry Needling (TDN) involves placing a small needle into the muscle at the trigger point. This causes the muscle to contract and then release, improving flexibility of the muscle; therefore, decreasing symptoms.
TDN is a valuable treatment for musculoskeletal pain. Like any treatment, there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving consent to treatment.

Risks of the procedure:
Though unlikely, there are risks associated with TDN. The most serious risk associated with TDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication.

Other risks may include bruising, infection and nerve injury. Please notify your provider if you have any conditions that can be transferred by blood. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from TDN is unlikely.
Please consult with your practitioner if you have any questions regarding TDN.

Do you have any know disease or infection that can be transmitted through bodily Fluids? YES NO ***If you marked YES, please discuss with your practitioner.***

____
Please print your name

____
Signature Date

I was offered a copy of this consent and refused.________ (initials)

NOTE: There is a weekly fee of $5.00 to cover the cost of supplies. Payment should be made at your first appointment of each week.