DRAGONFLY
physical and occupational therapy

www.DragonflyTherapy.com
Office 207-433-7778 | Fax 1-866-220-5031
840 Hammond Street, Suite 2, Bangor, Maine 04401

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the Notice of Privacy Practices for Dragonfly Therapy. I recognize that I must give my written authorization to Dragonfly Therapy to release any of my protected healthcare information in instances beyond purposes for treatment, payment, certain healthcare operations, or in instances required or permitted by law.

Patient Name: _____ **DOB:** _____
(Please Print)

Patient or Authorized Representative: _____ **Date:** _____
(Signature)

INFORMED CONSENT FOR CARE AND TREATMENT

Physical therapy (PT) and occupational therapy (OT) involves the use of many different types of treatment and evaluations.

Dragonfly Therapy and its employees, volunteers, and students use a variety of procedures and modalities to help improve an individual's function. As with all forms of medical treatment, there are benefits and risks involved with PT and OT.

Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict a patient's response to therapy. We are not able to guarantee what a patient's reaction to a particular treatment may be, nor can we guarantee that treatment will improve the condition addressed by therapy. There are risks of pain, injury, or aggravation to previously existing conditions.

You have the right to ask your PT and/or OT what type of treatment is planned for you. You may discuss the potential risks and benefits of treatment and the outcomes of choosing not to receive treatment. You have the right to stop treatment at any time.

I acknowledge that my treatment program has been explained and all of my questions have been answered to my satisfaction. I understand the risks associated with treatment, and I wish to proceed.

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(Please Print)

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FINANCIAL POLICY STATEMENT

I. It is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy.
II. If any payments of medical benefits are made directly to you for services rendered by Dragonfly Therapy, you must promptly remit such payment directly to Dragonfly Therapy.
III. If your account balance is not paid in full within 60 days of receiving your first patient statement, the entire account balance shall be subject to a monthly finance charge of 1.00% (Annual percentage rate 12.00%) and monthly costs of rebilling/account maintenance charges of $8.00. These rates and charges are subject to change upon written notice 30 days in advance of changes.
IV. If any account balance should be placed with a collection agency or attorney for collection, the patient agrees to pay all costs of collection, including court costs, collection agency fees and/or reasonable attorney fees.
V. If you are a Workers' Compensation patient, Section IV does not apply to you. Be advised, however, that you may be responsible for your charges if your Workers' Compensation claim is denied.
VI. I authorize that the payment of my insurance benefits be made directly to Dragonfly Therapy for any services that are reimbursable by my insurance company, if I have one.
VII. Dragonfly Therapy has a returned check fee of $40.

PAYMENT AUTHORIZATION

(Initials required for all 4 statements)

_____ **Guarantee of Payment**
Initials — I understand that all payments designated as the "patient's responsibility" such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by the billing statement due date.

_____ **Home Health**
Initials — I certify that I am not currently receiving Home Health services. I understand that it is the Home Health agency's responsibility to provide therapy services. I understand that if I am currently receiving or will receive Home Health services, it is my responsibility to pay for therapy services provided by Dragonfly Therapy.

_____ **Cancellations**
Initials — All cancellations must be made 2 business days prior to scheduled appointments. Any appointments cancelled with less than 48 hours notice **may be** subject to a $25 fee.

_____ **No Shows**
Initials — Failing to arrive for your scheduled appointment without prior notice will result in a charge of $50.

I have read the above information and it has been explained to me. I accept the terms and conditions of the above and will be responsible for the payment of my account.

Patient Name: _____ **DOB:** _____
(Please Print)

Patient or Authorized Representative: _____ **Date:** _____
(Signature)

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Authorization for Release of Information

Authorization is not required for disclosing information related to treatment, payment, healthcare operations, or when disclosure is required by law

Patient Name:_____ Date of Birth: ____/____/____
First MI Last MM / DD / YYYY

I only authorize the release information to the individuals/entities identified below by name, and I allow these individuals to release information to Dragonfly Therapy:

Spouse: _____ Friend:_____
Parent: _____ Other:_____
Dtr/Son: _____ Other:_____

Please choose one:

___ I **DO NOT** wish to review identifiable health information from the above facility prior to release.
___ I **DO** wish to review identifiable health information from the above facility prior to release. I will present to the facility named above to review the records prior to release.

Dragonfly Therapy will only disclose the protected health information authorized by the patient. I authorize the release of all information unless described or marked below:

_____ Correspondence re: your Therapy Services
_____ Chemical/Alcohol Dependency
_____ Evaluation/Examination
_____ Psychiatric/Psychological Problems
_____ Past Medical History
_____ AIDS/HIV Testing
_____ Treatments
Other:_____

Check only one, indicating how long Dragonfly Therapy can use this authorization:

_____Disclose my information indefinitely (as long as Dragonfly Therapy has custody of my files)
_____Disclose my PHI for the following period beginning ___/___/_____ and ending ___/___/_____

By signing I acknowledge:

*I understand that this authorization does not expire unless I have indicated an expiration date above.
*I understand that I can refuse to give authorization without fear of retaliation or treatment limitations.
*I understand that if I give authorization, I may revoke it at any time by notifying Dragonfly Therapy in writing.
*I understand that the information used/disclosed as a result of my authorization may be subject to re-disclosure by the recipient and may not be protected by Federal privacy regulations once in the recipient's possession.
*I understand that if my authorization is requested, Dragonfly Therapy is required to disclose the purpose of releasing my PHI (protected health information) and the individuals to whom my PHI is released.
*I understand that I will receive a copy of this authorization after I sign it and before I sign, if I request it.
*Dragonfly Therapy will not be compensated for using or releasing my PHI (apart from related treatment or payment procedures) unless specific authorization is obtained from the patient following full disclosure of purpose and intent.

_____ _____ _____/_____/_____
Signature of Patient or Representative **Relationship** **Date**

_____
Witness Signature

You May Refuse to Sign this Authorization

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Past Medical History

Patient Name: _____ **Date of Birth:** ___/___/___
Primary Care Provider: _____ **Other Specialist (s):** _____

In the last 30 days have you received services from a hospital, nursing home or home health agency? YES / NO If yes, who: _____ **When:** _____

What are we seeing you for? _____

Have you seen any other medical providers for this issue? YES / NO
__ PCP __ PT __ OT __ Chiropractor Other: _____

Have you had images for this issue or a related problem? YES / NO
__ X-Ray __ CT Scan __ MRI __ Ultrasound
When: _____ **Where:** _____

Surgical History:
Heart Surgery (pace maker, stents, etc.): _____ **Date:** _____
Surgery: _____ **Date:** _____ **Surgeon:** _____
Surgery: _____ **Date:** _____ **Surgeon:** _____

On a scale of 0 – 10 please rank your pain. Zero is pain free, 10 is the worst pain.
Pain: _____ **Location:** _____ **Start date:** _____

How many times have you fallen in the last 12 months? _____
How did you fall? (slip, trip, etc.) _____**Did the fall result in injury? YES / NO**

Medication List: YES / NO
Please list your medications below if list is not provided:
1. _____ 2. _____ 3. _____

YES	NO		YES	NO	
		High Blood Pressure			Epilepsy / other seizure disorder
		Heart Disease / Heart Attack			Problem w/ eyes (glasses / contacts)
		Allergies (latex / tape)			Problems w/ ears (hearing aid?)
		Stroke			Lung problems (COPD / Asthma)
		Diabetes			Bleeding Disorders (blood thinner)
		Cancer			Arthritis
		Osteoporosis			Dizziness / Vertigo (current / past)
		Metal Implants (including IUD's, bullets, staples, plates, etc.			

Signature: _____ Therapist Signature: _____