TOTAL BODY PHYSICAL THERAPY

Patient Intake Form

Name:_____ Date:_____

Address:_____
Street City State Zip

Home Phone:_____ Cell/Other:_____

Email:_____ Cell Carrier:_____

Would you like appointment reminders sent to your (please circle one) email or cell* or none?

Standard text rates and data usage may apply. You will be responsible for any charges.

Date of birth:_____ SS#:_____

Emergency Contact:_____ Phone:_____

Relationship:_____

Referring Physician:_____ Phone:_____

If referred by someone other than a physician, whom can we thank?

_____ Phone:_____

Employer's Name:_____ Phone:_____

Address:_____
Street City State Zip

_____

Primary Insurance

Company:_____

Policy Holder's Name:_____ Policy #:_____

Policy Holder's Date of Birth:_____ Group #:_____

Secondary Insurance

Company:_____

Policy Holder's Name:_____ Policy #:_____

Policy Holder's Date of Birth:_____ Group #:_____

I hereby accept responsibility for the cost of this examination, consult or treatment in the event the insurance company denies this claim.

Patient's Signature:_____ Date:_____

INSURANCE AND PAYMENT POLICY

General Fees: Initial Evaluation $180 Follow-up appointments $90
Women's Health Office or Extended Visits: $135

Payment is due at the time services are rendered for all insurance plans.

Connecticut state law allows physical therapists to evaluate and treat patients without an MD referral or medical prescription. However, many insurance companies still require their members to obtain this information. If an insurance plan requires a prescription or referral, and you do not obtain one, as a result, you will be responsible for all fees not covered by your insurance company.

We do not bill, nor accept a letter of protection from an attorney in lieu of payment.

This is not a guarantee of benefits. The information listed above was provided to us by the patient's insurance carrier with the information that is currently in their file. The insurance company will make final determination of benefits once they receive the bill. We will send the claim to the insurance company as a courtesy. However, ultimate responsibility for payment of services is the patient's or legal guardian's (if the patient is a minor). Disputes regarding benefits are between the patient and the insurance company. The patient is responsible for providing payment at time of service for all copays, deductible, and any remaining balance due from services that are not covered by the patient's insurance carrier. Please notify our office immediately if your insurance carrier or type of coverage should change. Failure to notify our office of any changes may result in denial by the insurance company, in which case payment becomes the patient's responsibility.

My signature below states that I have read, understand and agree to the provisions of this financial policy.

Patient Signature_____ Date_____

Notifier: **Identification Number:**

Patient Name:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If **Medicare** doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

What you need to do now:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** _____ listed above, I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

Medication List for:

Date:

Please list all medications, including all prescriptions, over the counter medications, herbals, vitamins, minerals, and dietary supplements. Include the dosage, frequency and administration method for each medication.

Medication	**Dosage**	**Frequency (please circle)**	**Administration (please circle)**
		• As needed • Once daily • Twice daily • Three times daily • Other_________	• Oral • Sublingual • Topical • Injection • Other_______
		• As needed • Once daily • Twice daily • Three times daily • Other_________	• Oral • Sublingual • Topical • Injection • Other_______
		• As needed • Once daily • Twice daily • Three times daily • Other_________	• Oral • Sublingual • Topical • Injection • Other_______
		• As needed • Once daily • Twice daily • Three times daily • Other_________	• Oral • Sublingual • Topical • Injection • Other______
		• As needed • Once daily • Twice daily • Three times daily • Other_________	• Oral • Sublingual • Topical • Injection • Other_______

Acknowledgment of Receipt of Notice of Privacy Practice

HIPPA REGULATIONS A photocopy of this Assignment shall be considered effective and valid as the original. I also authorize the release to any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance under the HIPPA guidelines.

Should you have any questions regarding this policy, please direct them to the Owner/Manager

By signing below, I acknowledge that I have read and understand this policy.

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Signature Relationship

CANCELLATION POLICY

I hereby understand and agree to accept responsibility of the cancellation policy of this office: **24 hour notice is required to cancel.** If I am unable to cancel within 24 hours or no show for the appointment, **a $50 fee will be charged for the missed session**. (Please note: this charge is your responsibility; the insurance company does not reimburse for missed appointments).

_____ _____

Patient Signature Date

_____ _____

Parent/Guardian Signature Date