Massage

Physical **THERAPY EXPERTS**, PLLC

Exercise

258 West 91st Street, Suite 1-B
New York, NY 10024
212-875-8345 T
212-875-0143 F

WELCOME

PLEASE FILL IN FORM COMPLETELY TO AVOID INSURANCE PAYMENT DELAY!

PATIENT INFORMATION

Patient:_____ S.S.#_____

Address:_____ D.O.B._____

Home Phone:_____ Bus Phone:_____ Male___ Female___

Emergency contact:_____ Relation to Patient:_____ PH#_____

Do you have a written prescription for physical therapy from a referring doctor? Yes__ No___

PRIMARY INSURED INFORMATION

Insurance: _____ Ins. Tel#:_____ Insured S.S#: _____

Insured : _____ Relation: Self__ Spouse__ Parent__ Other__
Last Name, First Name MI

ID#:_____ Group#:_____ D.O.B:_____ Male: ___ Female: ___

SECONDARY INSURED INFORMATION

Insurance: _____Ins. Tel#: _____ Insured S.S.# _____

Insured: _____ Relation: Self__ Spouse__ Parent__ Other_____
Last Name, First Name MI

ID#:_____ Group#:_____ D.O.B:_____ Male: ___ Female: ___

REASON FOR VISIT

Auto accident:_____ Employment Accident:____ Sport Accident:_____ Gradual Problem: _____

Date of accident:_____ Date of Surgery:_____ Diagnosis:_____

Other Info: _____

REFERRAL INFORMATION

Doctor Who Sent You: _____ Phone_____

Address: _____ City: _____ State: _____ Zip: _____

How Did You Hear About Us? *Please Circle One*

Doctor Friend/Neighbor AD Insurance Other: _____

CASE PROFILE AND HISTORY

What is your primary injury/problem/complaint?:_____

_____ Date of onset: _____

Have you been treated by Physical Therapy this year? YES NO

Past Medical History:_____

Current Medications: _____

Past Surgery or Hospitalizations:_____

Other Important Information: _____

The review of medical history and the physical examination are not considered treatment, but are part of the process of information gathering to determine future care.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that Therapy Experts will prepare any necessary reports and forms to assist me in collections from the insurance carrier including any amount paid directly to Therapy Experts which will be credited to my account upon receipt. I authorize my insurance carrier to pay Therapy Experts directly. However, I clearly understand and agree that all services rendered to me are my personal responsibility with regards to payment. If I suspend or terminate my care and treatment, all monetary balance after insurance payment will be due immediately from me directly. If I choose to ignore my responsibility, I agree to be liable for all collection and attorney fees if deemed necessary to recover the balance due. This applies to all Federal, Commercial, Self-Pay, Co-Pay, Denied Worker's Compensation, Medical Lien, No-Fault Claims and any other means of payment/reimbursement. Additionally, Therapy Experts **reserves the right to charge a $50.00 fee for cancelled or broken appointments without 24 hours advanced notification.** This fee is my direct responsibility and will not be billed or paid by my insurance carrier.

_____ _____

SIGNATURE DATE GUARDIAN SIGNATURE DATE

Massage Acupuncture
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MEDICARE BENEFITS, ASSIGNMENT & PATIENT RESPONSIBILITY

Printed Name of Beneficiary _____

Medicare Identification # _____

Please read the following information that you should be aware of regarding your Medicare Benefits for Physical Therapy and authorization you will be providing us:

1. This office is a participating provider of Medicare

2. Medicare requires their beneficiaries to satisfy a $135.00 yearly deductible before they will begin paying benefits. After your deductible is satisfied, Medicare will reimburse 80% of what they consider to be an "Approved Fee" providing they do not exceed the charges. An exclusion fee is a charge that is not covered by your Medicare plan. Medicare states that in this case, the patient is responsible for the actual charge billed by the provider.

3. In-Office, Outpatient Physical Therapy benefits are limited to 80% of Medicare's "Fee Schedule". Medicare will allow approximately 12-15 treatments per year; $1,810.00 total benefit.

4. On assigned claims, the beneficiary/patient is responsible for the co-insurance (20% of the approved charges to a maximum of #362.00) and the deductible ($135.00) and any exclusion fees described in #2.

5. Your 20% co-insurance is payable at the time of service unless you have secondary coverage with no "Out of Pocket" requirements. Also, the $135.00 deductible must be satisfied with our office if it has not been previously satisfied with another provider.

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Please turn this page over to complete this form.

6. "I request that payment of authorized Medicare benefits be made on my behalf to THERAPY EXPERTS, PLLC or JOHN R. MARTINEZ, PT, MPT for any services furnished to me by this provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine benefits or the benefit payable for related services. I also authorize THERAPY EXPERTS, PLLC or JOHN R. MARTINEZ, PT, MPT to obtain and release my medical information as needed."

7. To continue Physical Therapy treatment beyond thirty (30) days, Medicare now requires that you return to your doctor within thirty (30) days of your last dated referral to determine medical necessity for continued care. Without documented cause from your doctor and your therapist, Medicare may deny benefits. Therefore, if Physical Therapy is expected to continue beyond each thirty (30) day period, you are advised to return to your doctor within each thirty (30) day period.

We know that Medicare benefits can be difficult to understand so we are making every effort to assist you. If you have further questions, please ask our office manager or contact your Medicare representative.

"I have read the information above regarding my Medicare benefits and understand what my responsibilities are as the beneficiary/patient. This authorization is in effect until I choose to revoke it in writing."

_____ _____

Signature of Patient/Beneficiary Date

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- Obtaining payment from third party payers (e.g. my insurance company).
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20_____.

Print Patient Name:_____

Relationship to Patient:_____

Signature:_____

Practice Name: Therapy Experts
Address: 258 West 91st Street Suite 1
City/State/Zip: New York, NY 10024