TOTAL BODY PHYSICAL THERAPY

IN-NETWORK 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:_____ 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

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 do we 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 co-pays, co-insurances, deductibles, 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_____

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_______

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

HIPAA 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 HIPAA 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