TOTAL BODY PHYSICAL THERAPY

OUT-OF-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:__________________

GOOD FAITH ESTIMATE FOR
OUT OF NETWORK, UNINSURED, AND SELF-PAY PATIENTS

Thank you for choosing Total Body Physical Therapy to assist you in your recovery. We are an out-of-network provider with your insurance company. This means that we do not participate in your healthcare plan and the cost of physical therapy may be higher for you as a result. You have been informed of this and still agree to be treated by our office.

By signing this form, you agree to pay the Evaluation visit fee of $200 and each follow-up visit fee of $100. Payment is due at the time services are rendered.

Please note your healthcare plan might not apply any/or a portion of the amount you pay towards your deductible and out-of-pocket limit. You may contact your healthcare plan for more information on this.

You as the patient (or legal guardian of a patient or minor) have been informed of your out-of-network coverage and you have called your insurance carrier for additional information. You understand that there is an option to seek in-network care but would still like to be treated by our office.

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. 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 any 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/Guardian Signature____________________________ Date__________ Time________

Therapist Signature__________________________________ Date__________ Time________

NPI:38-3990481 Tax ID:1083075832 Plan of Service Code:11

Estimated visits: Frequency___________________________ Duration:_______________________
Frequency and duration will be re-assessed as patient progresses and a new GFE will be signed as needed if additional visits are deemed necessary beyond the original estimated projection.

Please take a picture of this agreement or we will provide you a copy of this page for your records.

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

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