Physical Therapy & Sports Medicine Center

PIP/LITIGATION PATIENT INFORMATION-

SECTION 1: PATIENT DEMOGRAPHICS

Social Security#: ____________-_____________-_____________ Appointment Date :______/_______/_______

Patient Name: ____ Birth Date: _________/__________/___________

Address: ____ Age: _____ Sex:_____ Marital Status: _____

City: _________________________State: _______ Zip: _________

Guarantor Name :____________________________ DOB:___________ Phone: (________)-__________-______________

Email Address: ____ Cell Phone:(_________)-_________-___________

Guarantor Employer: ____ Work Phone:(_________)-_________-__________

Employer's Address: ____

Emergency Contact: ____ Contact Phone: (_______)-_________-___________

Relationship: ____

Primary Care Physician/ PCP: _____________________________ PCP's Phone: (_____)-______-_______

*How did you hear about our facility? _________________________________

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SECTION 2: REFERRAL INFORMATION

Name of physician who referred you to physical therapy: ____

Referring physician's Phone: (______) - _________-________

SECTION 3 – HEALTH INSURANCE

-PRIMARY INSURANCE-

Primary Health Insurance: ____

Policy #: ______________________Group#: ________________Insured Name: ______________________________________

Subscriber Name: ______________________________ Subscriber DOB:_______________________

Insurance Phone: (______)-_________-________ ext.:________ Fax (______)-________-_________

-SECONDARY INSURANCE-

Secondary Health Insurance: ____

Policy #: ______________________Group#: ________________Insured Name: ______________________________________

Subscriber Name: ______________________________ Subscriber DOB: _______________________

Insurance Phone: (______)-_________-________ ext.:________ Fax (______)-________-_________

SECTION 4 - CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Physical Therapy & Sports Medicine Center to furnish medical treatment, including dry needling treatment, to (please PRINT name)

____

Considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian Signature____Date:_________________________________

SECTION 5 - BENEFIT ASSIGNMENT/ RELEASE OF INFORMATION

I, hereby assign all medical and/or surgical benefits to include major medical benefits to **which** I am entitled, including Medicare, Medicaid, private insurance and third party payers to Physical Therapy and Sports Medicine Center. A photocopy of assignment is to be considered as valid as the original. I, hereby authorize said assignee to release information necessary including Medical Records to secure payment.

Patient/Guardian Signature____Date:____________________________________

SECTION 6 - AUTO ACCIDENT CASE

Keep in mind that PTSMC MUST have proper verification from the adjuster that this claim is approved BEFORE you can be scheduled for an appointment.

1. Is this an Auto Accident claim? Y N

2. Accident/Injury Date: ___________________________ State in which accident occurred:________________

3. What is YOUR primary auto insurance company's name?____

4. Your auto claim number:____

5. Claim adjuster's name:____

6. Claim adjuster's phone and fax and email: ____

7. Has your adjuster approved physical therapy visits? ____________________

8. Have you submitted your PIP application? Y N

9. Did the police come to the accident? Y N

10. Did the police write a report? Y N

11. Do you have a copy of the report? Y N Provided copy to PTSMC? Y N

12. Were you given a ticket for the accident? Y N Was the other driver given a ticket? Y N

13. Is the other driver going to say the accident was your fault? Y N

14. Do you own any other cars? Y N

15. Does anyone else in your home own a car? Y N (you may be able to use their PIP)

16. How much property damage was done to your car? _______________________

17. How much property damage was done to the other car?______________________

SECTION 7- LITIGATION CASE

Is there an attorney assigned to this case: Y N

If no, do you plan on retaining an attorney: Y N (We must be notified immediately if attorney is retained or changed)

If yes, please print the name of the law firm / attorney: ____

Attorney Phone: (_______)-_______-_______ Fax:(_______)-_______-_______ E-mail:______________________

Have you signed PT&SMC's Attorney Authorization (AA) form: Y N

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SECTION 8

FINANCIAL POLICY STATEMENT

Please read and initial each of the following and sign and date at the bottom.

Physical Therapy & Sports Medicine Center (PTSMC) will bill your insurance carrier solely as a courtesy to you. Once the explanation of benefits is received by our office, if any outstanding balance and deductible it will be billed and mailed directly to you at the mailing address you provided. You are responsible for the entire bill when the services are rendered.

NOTE: The below does not apply for those patients that are considered Worker's Compensation or PIP/Auto Accident patients. However, be advised if you claim Workers Compensation benefits or receive a settlement based on an auto accident and are subsequently denied such benefits, **patient will** be held responsible for the total amount of charges for services rendered.

_____ Initial — It is the patient's responsibility to pay all co-pays, co-insurance, deductibles, or "cash pay" estimated amounts at the time of service.

_____ Initial — The patient agrees to assign all medical benefits to PTSMC for services provided. If any payment by patient's insurance company is made directly to patient for services billed by PTSMC, patient recognizes an obligation to promptly remit same to PTSMC.

_____ Initial — If for any reason the insurance company does not pay for the covered services provided within 60days, the patient shall assume responsibility for the total amount owed.

_____ Initial — It is the patient's responsibility to pay all uncovered services and balances within 30 days of receiving their financial statement.

_____ Initial — Patients who have a previous balance and wish to receive additional services are required to pay all previous balances in full prior to time of service.

_____ Initial — In the event that patient's insurance company requests a refund of payments made, patient will be responsible for the amount of money refunded to patient's insurance company.

_____ Initial — Patient has been advised that if the patient fails to make any of the payments for which the patient is responsible in a timely manner, the patient will be responsible for all costs of collecting monies owed, including the recovery of court costs, collection fees and attorney fees (If applicable), as well as interest of 10% owed on any outstanding balances, and the patient will be discharged from treatment for non-compliance.

_____ Initial — Returned checks will result in a $40.00 Service Charge.

_____ Initial — Patient understands in the event a payment is made via credit card, and a refund is required. Payment will be refunded **ONLY** to the credit card originally used, please allow 15 days to process. If payment was made with cash or check the refund will be issued by check, please allow 30 days to process refund.

I have read the above information and certify that I understand and will abide by the above policies set forth by Physical Therapy and Sports Medicine Center.

______________________________ ______________________

Patient/Guardian Name (please print) Date

______________________________ ______________________

Patient/Guardian Signature (parent or legal guardian if minor) Witness Name (Front Desk PTSMC

Physical Therapy & Sports Medicine Center

SECTION 9 - Personal Injury Protection (PIP)/Auto Accident Claim Patients

_____ The patient understands that PTSMC shall bill any available auto insurance company to recover any initial and all PIP money due and owing to me, to pay for my PTSMC medical bills.

Initial

_____ The patient understands that PTSMC must be informed if patient retains an attorney or makes a change in attorney.

Initial

******* PLEASE CHOOSE ONE OPTION******

1. I hereby instruct PTSMC NOT to bill my health insurance and I do so for the following reasons:
*Possible increase in future premiums.
*Possible treatment limitations.
*I can't afford the copays/deductibles.
*Possible adverse effect of Employer group plan.
*My attorney will settle the balance after litigation.
(Attorney must sign AA form)

Initial _______________

OR

2. I hereby instruct PTSMC to bill my health Insurance after my PIP exhausts.

Initial ________________

I have read the above information and certify that I understand and will abide by the above policies set forth by Physical Therapy & Sports Medicine Center.

____
Patient/Guardian Name (please print)

____
Date

____
Patient/Guardian Signature (parent or legal guardian if minor)

____
Witness Name (Front Desk PTSMC)

Physical Therapy & Sports Medicine Center

SECTION 10

ASSIGNMENT AND AUTHORIZATION

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You are hereby authorized to disclose and/or furnish my attorney(s) with any and all medical information, bills and/or records in your possession which they request in reference to any illness and injuries which I have suffered.

I further, irrevocably assign to you, and authorize and direct said attorneys to pay from the proceeds of any recovery in my case all reasonable fees for services provided by you, including fees for preparation and testimony, as a result of the injury or condition heretofore mentioned. I understand that this is in no way relieves me of my personal primary obligation to pay for such services and that the signing of this form does not prohibit customary billing by you. All bills shall be paid promptly in the usual manner. This specifically includes but is not limited to any and all Pip, Med-Pay, or Med Expense payments.

It is further understood that there is a Statute Of Limitations applicable to any civil claim you may bring. In view of this, I hereby agree that the Statute Of Limitations with respect to any claim for services mentioned above will ***not*** begin to run until I send you a denial, in writing, of any outstanding balance. Said written denial ***must*** be mailed certified mail, return receipt requested, and said return receipt will be required to show proof of the notice of this denial.

Patient Name:_________________________ Patient/GuardianSignature: ________________________________

Witness: _________________________________ Date: __________________________________

(Front Desk PTSMC)

THE UNDERSIGNED ATTORNEY FOR THE PATIENT REFERRED TO ABOVE HEREBY AGREES TO COMPLY FULLY WITH THE FOREGOING "AUTHORIZATION AND ASSIGNMENT" AND AGREES TO ADVISE THE NAMED ASSIGNEE IN WRITING THE STATUS OF THE CLAIM OF THE PATIENT WITHIN TEN (10) DAYS OF THE REQUEST, AND AGREES TO NOTIFY THE ASSIGNEE IF THE ATTORNEY CEASES TO REPRESENT THIS PATIENT AND/OR IF THE CLAIM IS DROPPED OR DENIED.

Attorney Name:___________________________ Attorney Signature:___________________________

Email Address:_________________________________ Date:______________________________

Physical Therapy & Sports Medicine Center

Section 11

ASSIGNMENT OF BENEFITS

AND RIGHT TO SUE FOR PIP

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To Whom It May Concern:

I hereby authorize and direct any insurance company with whom I may make a claim for PIP or Med-Expense benefits, and/or my attorney, to pay directly Physical Therapy and Sports Medicine Center, hereinafter referred to as “this health provider”, and any money that is owed to this health provider for services provided to me.

In the event that any insurance company that is obligated to reimburse me for charges I incur with this health provider refuses to make such payments after demand is made by either me or this health provider, I hereby assign and transfer to this health provider any and all causes of action that I have against said insurance company, including but not limited to the right to bring a lawsuit, for the failure to pay the available PIP and/or Med-Expense benefits up to the amount of this health provider’s full bill.

I authorize this health provider to bring any such cause of action either in my name or in this health provider’s name. I further authorize this health provider to compromise, settle or otherwise resolve any such claim arising out of available PIP or Med-Expense benefits up to the amount of its full bill.

I understand that I remain personally responsible for the total amounts due to this health provider for its services. I understand that payment is due at the time services are rendered, and that this health provider is providing a courtesy to me by trying to have the bill paid through alternative sources. I agree that this document does not constitute any consideration for this health provider to await payment, and that payment may be demanded from me immediately upon the rendering of services.

I authorize this health provider to release any information pertinent to my case to any insurance company or attorney to facilitate the collection of my bill. I agree that this health provider be given Power Of Attorney to endorse or sign my name on any and all checks for payment of my doctor bill.

Patient Name: ____

Patient/Guardian Signature: ____________________________________

Date: ____

Physical Therapy & Sports Medicine Center

SECTION 12

Patient Authorization and Disclosure of Protected Health Information Statement of Privacy Act.

We may disclose your health care information:

1. To other healthcare professionals within our practice for the purpose of treatment, payment or health care operations.
2. To insurance provider for the purpose of payment or health care operations.
3. To comply with State Workers' Compensation laws
4. To public health employees for preventing/controlling disease and reporting infectious exposures.
5. In the course of any administrative of judicial proceeding or law enforcement purposes

Under HIPPA Federal Privacy law, you have the right to:

1. Request restrictions on certain uses of your health care information
2. Inspect and copy your healthcare information
3. Receive an accounting or disclosures of your protected health information made by us.
4. You have a right to a paper copy of this Notice of Privacy Practices at any time, upon request.

We reserve the right to amend this notice of Privacy Practices at any time in the future. We are required by law to maintain the privacy of your healthcare information.

If you have any questions regarding this notice or if you want more information about your privacy rights, please contact us at 301.446.1644.

Release of Information

[ ] I authorize the release of information including the diagnosis, records;
examination rendered to me and claims information. This information may be released to:
[ ] Spouse____
[ ] Child(ren)______________________________________
[ ] Other____
[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

My signature indicates my authorization and consent for Physical Therapy and Sports Medicine Center to use and disclose my protected health care information for the purposes of treatment, payment and healthcare operations as described above.

Patient's Name (PRINT): ____

Patient/Guardian Signature: ________________________________Date: ________________

Physical Therapy & Sports Medicine Center

SECTION 13

Cancellation and No-Show Policy

- We ask that you help us to serve you by keeping your scheduled appointment. Appointments that are missed or cancelled at the last minute are not able to be given to other patients who need an appointment.
- You must be on time, so that you can be given the full benefit of your therapy session.
- Any patient who arrives more than 15 minutes late may not be seen by the therapist, AND a **cancellation charge of $50.00** will be applied. If a patient is running late, it is asked that you call our office and let us know so that we can inform the therapist.
- **PT&SMC requires at least 24 hours-notice for appointment cancellation. Any appointment that is cancelled the same day or within less than 24 hours will result in a $50.00 cancellation fee**.
- **This fee must be paid before one can be checked in at the next appointment.**
- **No-shows are a $50 charge**
- **Understand that if you do not show up to an appointment, without notice to our office, any future scheduled appointments will be removed from the system. The $50 fee must be paid in order for the next appointment to be scheduled.**
- **Three episodes of not attending physical therapy (no-show) will result in patient discharge from therapy.**
- **In the case of medical emergency, proper documentation (doctor's note etc.) must be provided.**

Non-Compliance Clause

- Any patient who has 3 consecutive appointment cancellations or no-shows, will be discharged from physical therapy for non-compliance and your referring physician will be notified. It is important for you to stick to the prescribed treatment plan in order for it to be as effective as possible.

The above information has been read and explained to me. I understand this office policy.

Patient/Guardian Signature: ____Date_________________________________

Physical Therapy & Sports Medicine Center

SECTION 14

Email and Text Messaging Program Consent Form

Patient Name: ____

We are happy to provide our patients with the option to participate in our online patient communication system.

Some of the features include the ability to:

1. Request appointments via website
2. Confirm appointments via text message
3. Receive text/email/voice message appointment reminders
4. Submit patient satisfaction surveys
5. Receive PTSMC communication via text/email(i.e. newsletter, announcements, updates and promotions

Please select **ONE** of the following methods you wish to be reminded of your appointment:

- ☐ **TEXT ME AT THIS CELL # ____________________**

  OR

- ☐ **LEAVE ME A VOICE REMINDER AT THIS NUMBER__________________**

You may choose to discontinue your participation in our online communication system at any time simply by clicking the “unsubscribe” link found at the bottom of each email, or by replying “STOP” to a text message from us. Standard text messaging rates may apply.
We use this information strictly for the purposes of communicating with you more efficiently. Our goal is to provide you with excellent treatment as well as overall service and satisfaction.

Please sign below to indicate that you agree to allow us to use this information in providing your services.

____

Patient/Guardian Signature Date