AUTO/ WORKERS' COMPENSATION INSURANCE

□ Auto Insurance □ Workers' Comp Insurance **Date of Accident:** _____/_____/_____

Insurance Company:________________________ **Relationship to Patient:**________________________

Address:____

City State Zip

Adjuster/Contact Person:________________________ **Phone Number:**________________________

Claim#:____

Attorney's Name:________________________ **Phone Number:**________________________

Address:____

City State Zip

Insured's Name: ________________________ **Insured's Date of Birth:** _____/_____/_____

MEDICAL HISTORY

Are you currently under the care of a physician? □ Yes □ No **If yes, explain**: ________________________

____

Name of physician: ________________________ **Phone #**: ________________________

Date of last visit to physician: ________________ **Do you have a referral for physical therapy**? □ Yes □ No

Most recent diagnosis related to this visit: ________________________

Do you have any health problems? **Please list**: ________________________

____

Please list <u>any</u> prescription or over the counter medications you are taking: ________________________

____

Have you ever had physical therapy before? □ Yes □ No **If yes, explain**: ________________________

____

Have you had any of the following?

__ Coronary Heart Disease
__ Stroke
__ Hernia
__ Cancer
__ Congestive Heart Failure
__ Shortness of Breath
__ Emphysema
__ COPD
__ Peripheral Vascular Disease
__ Heart Attack
__ Epilepsy
__ Bowel/Bladder Problems
__ Angina
__ Recent Weight Loss
__ Dizziness/Fainting
__ Systemic Disease
__ Allergies
__ Diabetes
__ Congenital Heart Disease
__ Osteoporosis
__ High Blood Pressure
__ Infectious Diseases
__ Asthma
__ Eating Disorder
__ Irregular Heartbeats/Murmurs

Orthopedic/muscular problems:

__ Back Pain
__ Shoulder Injuries
__ Knee Injuries
__ Foot Injuries
__ Neck Injuries
__ Arthritis (Rheumatoid)
__ Broken Bones
__ Arthritis (Osteo)
__ Joint, Tendon, or Muscular Pain

Please explain any of the above:

____

____

____

Patient Registration and Consent for Medical Treatment

1. <u>**Consent for Health Care Services**</u>: I authorize consent for medical treatment at ***Bridgetown PT.***
2. <u>**Authorization for Release or Information**</u>**:** ***Bridgetown PT*** may release information from my medical records to any health care provider involved in my care and treatment. ***Bridgetown PT*** may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, ***Bridgetown PT*** is no longer responsible for the confidentiality of any information known or possessed by the payer.
3. <u>**Financial Agreement**</u>**:** I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by ***Bridgetown PT*** which are not paid by my health insurance or other payer. All charges are due and payable when I receive the bill. If Payment is not made within 90 days from the date the bill was mailed from ***Bridgetown PT,*** I understand that a delinquent charge of interest rate of 18% may be added to my bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with ***Bridgetown PT***. I understand that I am responsible for a $40.00 returned check fee in addition to any other associated bank charges.
4. <u>**Preauthorization Requirements**</u>**:** I accept the responsibility to obtain all referrals or preauthorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of ***Bridgetown PT*** charges.
5. <u>**Assignment for Direct Payment**</u>: I authorize that payment of any insurance (including auto insurance and health-care insurance) benefits for health care services or goods may be made directly to ***Bridgetown PT*** charges not paid.
6. <u>**Charge for No Show/Cancellation without 24 hour notice:**</u> I understand that 24 hour notice is required for canceling an appointment, and I will be charged a $25.00 fee for any missed appointment without required notification. I also understand that I will be responsible for this charge and that my insurance company will not be billed for that day.

I acknowledge that:
- **I have read this form and understand its contents.**
- **I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms.**
- **I am responsible for the payment and/or co-payment that is due at the time of service.**
- **I have received a copy of *Bridgetown PT.* HIPAA Policy**

______________________________	______________________________
Signature of Patient or Legally Responsible Person	**Name (PRINT)**
______________________________	______________________________
Relationship/Reason Why Patient is Unable to Sign	**Date**

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION.

Bridgetown Physical Therapy and Training Studio is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and abide by the terms of the notice that is currently in effect.

"Protected health information" includes any identifiable health information that we obtain from you or others that relates to the past, present, or future healthcare and treatment or the payment for your healthcare or treatment. Healthcare information may include health history and status, test results, diagnoses, and physical therapy treatments.

Bridgetown Physical Therapy and Training Studio reserves the right to change the terms of this notice and to make the revised notice effective for all protected health information we maintain. You may request a copy of the most current privacy notice.

The following describes how the clinic is permitted to use or disclose your health information:

- The coordination or management of your health care, including contact with other health care providers directly related to your care
- Activities for payment, including contact for eligibility for health plan or insurance coverage and submitting claims
- Support for treatment and payment such as quality assurance and administrative duties
- When required by federal, state, or local law
- To avert a serious threat to health or safety

Your Rights Regarding Your Health Information:

- You have the right to obtain a copy of the health information from the clinic
- You have the right to submit in writing an amendment to the information about you if you believe the information is incorrect
- You have the right to request a restriction or limitation of your information that we use or disclose about you, but we are not required to agree to your request
- You have the right to ask us to communicate with you at a special address or by a special means, if you believe that the disclosure of certain information could endanger you
- You have a right to complain about our privacy practices, if you think your privacy has been violated
- You have a right to receive a paper copy of this notice

I have read and understand the information above and have been offered a copy of the Notice of Privacy Practices.

NAME/ GUARDIAN:______________________________

SIGN NAME:____________________________________ **DATE:**__________________________

Financial Policy and Agreement

This is an agreement between Bridgetown Physical Therapy and Training Studio, PC and the patient named on this form. By executing this agreement, you are agreeing to pay for all services and supplies that are received. **Any co-payments required by an insurance company must be paid at the time of service. Any co-insurance must be paid within 28 days of receiving a billing statement from Bridgetown Physical Therapy.**

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. As contracted providers with your insurance company, we agree to accept the allowable amount (usual and customary) established by your insurance company.

Although we may estimate what your insurance company may pay as well as the patient's portion, it is the insurance company that makes the final determination of payment and eligibility.

Billing Insurance: As courtesy to you, we will verify your insurance benefits and eligibility prior to your first appointment. Verification of benefits is an estimate of what your insurance company will pay. It is the patient responsibility to be aware of your own benefits and eligibility.

If your insurance company notifies us that they are waiting to receive the accident report form from you, the balance is automatically patient responsibility and we will begin collection procedures unless prior arrangements have been approved by the clinic.

Out of courtesy and convenience to you, we will bill your primary insurance followed by your secondary insurance. If your insurance company does not remit payment within 90 days from the date first billed to your primary and secondary insurance, the balance in full will become patient responsibility.

Referrals/Prescription/Authorization: If your insurance company requires a prescription for physical therapy, it is the patient's obligation to provide a copy to our clinic. Your insurance company will not reimburse for claims without a required prescription.

Workers Compensation: We require approval/authorization by worker's compensation carrier prior to your initial visit. If your claim is denied, payment shall be made by billing private medical insurance or patient. If your claim is in litigation, we do require verification of this from your attorney and/or worker's compensation carrier.

Personal Injury /Motor Vehicle Accidents (MVA): MVA claims are handled through your personal auto insurance, regardless of who was at fault in the accident. If someone else was responsible for your accident, we understand their insurance will be covering your medical expenses, but it is standard industry practice to bill your insurance first so they can maintain accurate records on your behalf and work to have those expenses reimbursed in a timely fashion. If your insurance is covering all expenses, we will verify your PIP benefit to ensure you have that available coverage. If your PIP is exhausted, we can bill your private insurance for any remaining balance not covered. We will not put any accounts on hold, accept any letter of protection or wait for any litigation to be complete before obtaining reimbursement.

Missed Appointment Fee: A **$25** fee will be charged for missed appointments or appointments cancelled with less than 24 hours notice. This fee must be paid before a new appointment is scheduled or services provided. This fee is not billable or payable by insurance. Patients with more than two missed appointments may be discharged from therapy and referred back to their physician. We understand that emergencies do occur and will attempt to make reasonable accommodations for that.

I have read, understand, and agree to the *Financial Policy and Agreement* above:

Patient____________________________________ **Date**__________________

Guardian__________________________________ **Date**__________________