



PATIENT INFORMATION FORM

Name _____	Date of Birth _____ Sex F / M
Address _____	SS# _____
City _____	Date of Injury _____
State & Zip _____	Home Phone# _____
Employer _____	Alternate Phone# _____
Adjuster/Attorney _____	Phone/Fax# _____
PCP _____	Phone/Fax# _____
Referring Dr. _____	Phone/Fax# _____
Referred by _____	

Initial Appointment DATE & TIME _____ Chief Complaint _____

◆ Workers Comp ◆ Auto ◆ Health Insurance ◆ Self-Pay

PRIMARY INSURANCE INFORMATION	
HEALTH INS _____	SUBSCRIBER _____
ID # _____	RELATION TO SUBSCRIBER _____
Group # _____	DOB OF SUBSCRIBER _____
INS PHONE# _____	EFFECTIVE DATE _____

SECONDARY INSURANCE INFORMATION	
HEALTH INS _____	SUBSCRIBER _____
ID # _____	RELATION TO SUBSCRIBER _____
Group # _____	DOB OF SUBSCRIBER _____
INS PHONE# _____	EFFECTIVE DATE _____

INSURANCE VERIFICATION AND BENEFITS	
PT COVERED Y / N IN / OUT OF NETWORK	VISITS ALLOWED _____
DEDUCTIBLE _____	AMOUNT MET _____
OUT OF POCKET _____	COPAY/COINSURANCE _____
SEND CLAIMS TO _____	NOTES _____

Empower Physical Therapy makes every effort to verify insurance coverage for physical therapy services. Verifying coverage is no guarantee of payment. We will submit the claims to your insurance company and attempt to secure payment. Ultimately, it is the Clients Responsibility to be aware of insurance coverage. Empower Physical Therapy has the right to collect co-pays, co-insurance and/or deductible amounts at the time of your visit. If we are billing your auto insurance carrier, we will need your health insurance information as a back up.

AUTHORIZATION

I certify that I am covered by _____ Insurance Company and I assign directly to Empower Physical Therapy all insurance or workman's compensation benefits otherwise payable to me. I hereby authorize Empower Physical Therapy to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I understand that I am responsible for any balance not covered by my insurance per usual and customary rate.

Signature

_____/_____/_____
Date



PAYMENT AND COLLECTION POLICY

Payment is expected at the time of service. Unpaid balances left by your insurance companies will be your responsibility. In the event you are unable to pay the balance in full, we are willing to make reasonable payment arrangements. Check, cash, money order, and/or MasterCard and Visa are accepted forms of payment on the account.

Please be advised that Empower Physical Therapy is not a credit grantor and therefore, failure to maintain payment arrangements may result in the placement of your account with a collection agency or attorney for collection.

***Collection Policy:** In the event that we do not receive payment within 30 days of our billing you, our collections policy is as follows: Any past due payment will start incurring an 18.5% APR on day 31. On day 60, your account will be turned over to a collection agency if the balance is not paid in full or a payment plan has not been set up with the office manager. Please avoid this by keeping up with your payments and communicating with the office staff.

- ◆ **HEALTH INSURANCE:** Primary insurance will be billed by Empower Physical Therapy as a courtesy to you. Payment of insurance benefits is not forthcoming on charges older than 60 days; therefore outstanding charges regardless of insurance carrier will be due by the patient above and beyond co-pay, co-insurance, deductible, and/or primary coverage classified as “above usual and customary” upon receipt of the Explanation of Benefits.
- ◆ **MEDICARE:** Medicare will pay 80% of Medicare approved charges; therefore 20% will be collected as a co-insurance. Please check your Medicare Handbook for details about capitation and run-out benefits.
- ◆ **WORKERS COMPENSATION AND MOTOR VEHICLE ACCIDENTS:** Patients will be asked to provide the following information: Date of Injury, Claim Number, Billing Address, and any authorizations required for services to be rendered. We will obtain a copy of your health insurance card for submission of any balance not covered. The patient is responsible for any balance not covered.

ATTENDANCE POLICY

Empower Physical Therapy strongly discourages same day cancellations and failure to show for scheduled appointments. **Failure to give 24-hour notice or no show on more than two occasions may result in a \$30 charge and/or discharge from physical therapy.** We are cognisant of life circumstances such as illness or inclement weather that result in same day cancellations and do not penalize these absences as long as notice is given. Cancellations due to pain from your current injury are discouraged, as therapy sessions can be modified from session to session to better manage symptoms and increase functionality.

The therapist maintains the right to deny treatment if the patient arrives late to avoid any overlap with patients who arrive on time.

Absences will be made known to both employer and **Workers Compensation** Insurance through phone contact and progress notes for **Workers Compensation** cases.

Signature

Date



DEDUCTIBLE PAYMENT POLICY

Empower Physical Therapy is dedicated to providing the best services possible to our patients. As an administrative service to our patients we will submit medical claims and work with your insurance company to make sure your claims are properly handled. Please realize that your insurance plan is a contract between you and your insurance carrier and understanding the requirements of your plan is crucial for maximum benefit from service received.

In order to make our services more affordable for insurance plans with deductible amounts, our policy is an agreement between you and Empower Physical Therapy, separate from your insurance contract.

- We will contact your insurance company to ascertain out of network benefits.
- We will inform you of what your insurance company told us and try to answer any questions you may have regarding your plan benefits and financial responsibilities.
- We will give you an estimation of your financial responsibility based on the information we receive from your insurance carrier.
- Our deductible amount due from patients is \$120 for the first appointment and \$75 per visit for subsequent visits until your deductible is met.
- We will submit your claims, billing our standard charges to your insurance company so that your deductible can be met as quickly as possible with minimal cost to you.
- Once your deductible is met, your insurance company will begin paying the usual and customary amount and the coinsurance percentage will be the patient's responsibility.
- The coinsurance amount is based on the percentage of the amount allowed by the insurance for that date of service rather than the amount billed to the insurance. Based on your insurance the amount per visit toward your coinsurance will be _____.
- Once all benefits have been received from your insurance company, any balance or refunds due will be processed within 30 days of receiving the last Explanation of Benefits (EOB).
- Receipt for services can be submitted to flexible spending accounts.

Please make sure you have read this financial policy carefully before signing below. By signing below you have indicated that you have read and accept this financial agreement.

Patient/Guardian Signature: _____ Date: _____

Authorized Staff Signature: _____ Date: _____

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INFORMED CONSENT

I, _____ do hereby give my consent to have the clinical staff of Empower Physical Therapy provide therapy service(s) as prescribed by my treating physicians. I understand that the initial physical therapy evaluation will be performed by a licensed physical therapist. I reserve the right to refuse any test or procedure that has not been explained to my satisfaction. I have the right to receive the medical records generated by Empower Physical Therapy for a reasonable copy fee.

During the course of treatment, you may experience a temporary increase in symptoms, especially after the initial evaluation. In most circumstances this is a normal part of the recovery process, especially with manual therapy. It is important for you to inform the clinical staff of any difficulties or symptoms you are having first and foremost before immediately calling the doctor. You may contact this facility at any time to discuss your status if you believe that what you are experiencing seems out of the ordinary. Please remember that your care is our top priority. We want to provide you with as much information and education that we can to help expedite your rehabilitation and recovery.

Reports generated by Empower Physical Therapy will be directed to all involved parties. Referring physicians get a copy of all your reports. The insurance company administering your benefits will also receive a copy. If your injury is being handled by Workers' Compensation or an Auto Company, a copy of your reports will be directed to an employer representative or claims adjuster and any rehabilitation specialists monitoring your case. Please inform a staff member if you would like reports sent to any other doctors involved with your treatment.

Our staff is grateful for the opportunity to provide rehabilitation services to you.

Client Signature: _____ Date: _____



NOTICE OF PRIVACY PRACTICES

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This notice describes how health information about you as a patient may be used and disclosed and how you can get access to your individually identifiable health information. Please review this notice carefully.

Our commitment to your privacy:

Our practice is dedicated to maintaining the privacy of your personal health information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. You may request a copy of our most current Notice at any time. You may at any time access, copy, and amend your records, request confidential communications, obtain accounting of disclosures that require authorization, and place restrictions on the use of your PHI.

We may use and disclose your PHI in the following ways:

- **TREATMENT:** PHI may be disclosed to healthcare providers or others assisting in your care.
- **PAYMENT:** Our practice may use and disclose your PHI in order to bill and collect payment for the services rendered. For example, we may contact your health insurer to certify that you are eligible for benefits, and we may provide your insurer with details regarding your treatment to determine if your insurer will pay for treatment. PHI may also be sent to attorneys in lien or third party actions for payment.
- **HEALTHCARE OPERATIONS:** Our practice may use and disclose your PHI to operate our business including but not limited to the evaluation and review of the quality of care you received from us by our physical therapy provider network, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations. Finally, our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

All other disclosures of your personal health information will be made only with your written authorization and you may revoke that authorization at any time.

If you have questions about this Notice, please contact Rachel Miller, MS, PT, CFMT, Owner, Empower Physical Therapy, Inc. Effective 4-10-2008

I have been made aware and understand this Notice
Patient's Signature

Date