Specialized Physical Therapy
Moving You Forward

T: 978-664-4008
F: 866-949-9835
www.specialized-pt.com
161 Main St STE 3, North Reading MA

SPT Patient Intake Form – Page 1/3

Patient's Legal Name: _____ Patient Date of Birth: _____ Sex: M ☐ F ☐

Legal Home Address: _____ City: _____ Zip Code: _____ State: MA

Reason for PT Treatment? Fall: ☐ Car Accident: ☐ Workplace: ☐ Sports: ☐ Other: _____

Valid E-mail Address: _____ Phone Number: _____

Primary Medical Insurance: _____ Member ID #: _____

Policyholder (Subscriber) Name: _____ Policyholder Date of Birth: _____

Relationship to the Policyholder: _____ Medical Diagnosis: _____

Referring Physician: _____ Primary Care Physician: _____

Have prescription (< 30 days old) for PT (**required**): YES ☐ NO ☐ **Authorization** for PT in place: YES ☐ NO ☐ NOT NEEDED ☐

Today's Date: _____

Only for patients with School Insurance or two (2) Insurances such as Medicare and BCBS Supplement.

*Secondary Medical Insurance: _____ Policy Number: _____

*School or **Secondary** Medical Insurance Name: _____ Member ID #: _____

Welcome to our practice and thank you for choosing Specialized Physical Therapy (SPT) for your premium Physical Therapy (PT) Services. We are passionate about our practice and committed to providing you and your family with the highest quality of care. We look forward to the opportunity to restore your health to its maximum potential. Please initial the selected paragraphs and sign page three of this document to acknowledge that you have **READ, FULLY UNDERSTOOD and AGREED** to all of our policies, terms, and conditions. If you have ***any questions or concerns***, please call our clinic and our staff will be happy to assist you. PT service will not be rendered with incomplete or unsigned forms.

Out-of-Pocket Insurance Responsibilities Initial: _____

- Out-of-Pocket expenses include copayments, deductibles, and coinsurances and are **due at the time of service**.
- These out-of-pocket expenses are **PARTIAL PAYMENTS ONLY** and the final cost is determined by your insurance.

ATTENDANCE / CANCELLATION / RESCHEDULE / NO-SHOW POLICY: $79 FEE Initial: _____

- SEVENTY-NINE DOLLAR (**$79**) FEE
- Canceling or rescheduling an appointment without giving us AT LEAST 24 to 48 BUSINESS-DAY HOURS of NOTICE. Saturdays, Sundays, and Holidays do not count as notice as we are not open for business.
- Failing to show up ("NO SHOW") to a scheduled appointment with your Physical Therapist.
- Arriving 15 minutes late or more to ANY scheduled appointment.

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SPT New Patient Intake Form – Page 2/3

Collection Agency Fees, Legal Fees, Bank Fees, and Invoicing Initial: _____

- Invoices are **due on receipt**.
- Unpaid account balances will accrue a twenty dollar (**$20**) late fee *every thirty (30) days* starting at the invoice due date.
- Accounts that remain *unpaid thirty (**30**) days past the invoice due* date will be referred to **COLLECTIONS** at our discretion.
- SPT may at any time, without notice or demand, institute legal proceedings to collect unpaid debt; the patient or parent/legal guardian will be responsible for SPT's court, filing, and reasonable attorneys' fees we incur in such collection efforts.
- A **$25** fee will be charged for *each* returned check and only cash or credit card payments will be acceptable thereafter.
- Specialized Physical Therapy reserves the right to refuse service at any time for failure to pay invoices or account balances in full by their invoice due date.

Agreement and Payment for PT Services Initial: _____

- Your insurance policy is a contract between you and your insurance company. While we may accept your insurance as payment, your contract with us is a separate agreement.
- In other words, if your insurance or other third party refuses to pay your claim in full for any reason, refuses to cover a certain treatment, or otherwise fails to pay us, <u>your contract with us still exists, and you are responsible for payment personally for services rendered.</u>
- Rejected claims (partial or full and regardless of reason) will be billed at our current cash rates and will be non-refundable.
- SPT reserves the right to make policy, cash rate, and cancellation fee changes ANYTIME and WITHOUT PRIOR NOTICE.

Patient Responsibilities with Insurance Initial: _____

The patient or parent/legal guardian must provide **ACCURATE, TRUE, COMPLETE, and TIMELY** insurance, billing, third party, and health history information, determine whether our services are covered under your insurance plan, and ensure all insurance, attorney, and third party requirements are met for your plan prior to and throughout treatment. SPT does not guarantee the accuracy of any information obtained from your health insurance or any third party (since we neither own nor manage it), and the "passing along" of a patient's eligibility, benefits, and authorization is never a guarantee of payment to STP from your insurer. Over the course of treatment, the patient is obligated to **MONITOR** and immediately **NOTIFY** our clinic (in writing) in a **TIMELY** manner of any and all any changes, limits, modifications and/or amendments to the terms of the patient's insurance plan. The patient is responsible for ensuring that all insurance requirements such as, but not limited to, **<u>referrals, authorizations, applications (i.e. PIP), and PT prescriptions</u>** are active, valid, accurate, and faxed to our clinic prior to treatment and throughout treatment. Claim rejections (partial or full and regardless of reason) and appeals are the patient's responsibility. If we are not contracted with your insurer (or if you decide to go forward with treatment without your insurance authorization), our cash rate for service will apply; sending claims to any insurer or third party will not be permitted at any time forward since cash payment for service is final and non-refundable. If you have a Health Savings Account (HSA) or Health Reimbursement Account (HRA) and a deductible, please advise us immediately. Policy for patients considered minors (UNDER 18 YEARS OLD): The parent/legal guardian of a patient who is considered a minor is responsible for full payment.

Consent to Treat Initial: _____

As a patient receiving physical therapy services, you have the right to be informed about your condition and the recommended physical therapy treatment and procedures to be used over the course of treatment. You are provided with this information so that you can make an informed decision after being made aware of the potential risks and benefits of receiving physical therapy.
Generally, physical therapy involves the performance of a physical exam in order to determine how to treat your condition. This initial physical exam may include a number of different procedures and tests to help us determine how to treat your condition. As with any medical treatment over a course of time, there are risks and benefits associated with physical therapy. These risks include, but are not limited to, the potential that your injury or condition ***may increase*** or you may experience ***new injuries, pain, or conditions*** following the performance of certain treatments, procedures, exercises, modalities (such as but not limited to Electrical Stimulation and TENS, Ultrasound, Joint Mobilization, Massage, Heat, and Ice), or tests over the course of receiving our physical therapy service; furthermore, additional risks include but are not limited to new or exacerbated allergies, adverse reactions, injuries (i.e. falling down), or symptoms you may experience from massage creams and lotions, instrument gels and fluids, latex exercise bands, cleaners, and disinfectants.

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SPT New Patient Intake Form – Page 3/3

No Guarantees for Treatment Outcomes Initial: _____

You are aware that a patient's response to physical therapy may vary significantly from one patient to another and acknowledge that there are **NO GUARANTEES OR ASSURANCES**, and none have been made to you, that physical therapy treatment will help your condition or that you will achieve any specific result. Physical therapy is as much an art as a science and guaranteed outcomes are not possible.

You have the right to ask, and you should ask your physical therapist any questions that you have regarding the type of treatment that he or she is planning and the potential risks and benefits of such specific treatment. You have the right to refuse any treatment at any time for any reason.

You hereby consent to all physical therapy treatments, procedures, exercises, modalities, and tests that are deemed advisable by your physical therapist and/or referring physician. You acknowledge that your treatment program has been explained to you and you have had the opportunity to ask any and all questions that you desire and have had your questions answered to your satisfaction. Additionally, you understand the risks associated with physical therapy as set forth herein and outlined by your physical therapist, and you wish to knowingly and voluntarily proceed with physical therapy.

Authorization to Release Information Initial: _____

I authorize Specialized Physical Therapy to release my medical information to my *insurance company*, *physician*, *attorney*, *and all pertinent third parties* that may be involved in my insurance claim or care. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify SPT in writing. I understand Specialized Physical Therapy will consider the requests for restrictions on a case-by-case basis, but does not have to agree to requests for restrictions. I understand I have the right to revoke this consent by notifying the practice in writing at any time.

Medicare Patients Initial: _____

Medicare will not cover outpatient physical therapy if a patient is currently receiving home health services or begins to receive these services during their period of active treatment. It is the patient's responsibility to ensure they have been **FULLY DISCHARGED** from any home care service **before** starting outpatient physical therapy at our clinic. In addition the patient is responsible for **Medicare's Part B deductible** if their secondary insurance does not cover it or if we do not accept their secondary insurance.

Notice of Privacy Practices: Located on our website and at our clinic by request Initial: _____

The U.S. Federal Health Insurance Portability and Accountability Act (HIPAA) dictates that we maintain the privacy and security of your medical and health information, called Protected Health Information (PHI). We urge you to read the HIPAA documentation located online at http://www.hhs.gov/hipaa and the Notice of Privacy Practices located on our website (see our Patient Forms web page) prior to your first treatment. You agree and acknowledge that you have been offered the opportunity read our Notice of Privacy Practices located on our website or in our clinic.

By signing your name on page three of this document and choosing Specialized Physical Therapy, LLC for physical therapy treatment, the patient or parent/legal guardian certifies that the ***undersigned*** has read, fully understands, and agrees with all company policies, terms, and conditions, is **ALWAYS** primarily liable for any and all unpaid account balances for services rendered, and agrees to pay account balances in full when due; furthermore, if medical insurance rather than cash is chosen for payment and claims have been fully or partially rejected, denied, or unpaid for **ANY REASON**, the patient or parent/legal guardian agrees to pay **IN FULL** for services rendered.

PATIENT NAME (*Print or Type*): _____

PARENT or LEGAL GUARDIAN Name (*Print or Type*): _____

PATIENT or PARENT / LEGAL GUARDIAN **SIGNATURE**: _____ **Today's Date:** _____

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MATERIAL EVENTS THAT AFFECT YOUR MEDICAL INSURANCE PAYMENTS:

STOP PHYSICAL THERAPY IMMEDIATELY IF:

1. You **do not have an Authorization** in place.

2. You have **Changed insurances,** have no insurance, or cannot pay patient responsibilities (copay, deductible, or coinsurance) at the time of service.

3. You have been involved in an **Auto/Bicycle/Motorcycle Accident three (3) years prior** to the initial evaluation or **During Treatment.**

4. You have been involved in **Workers' Compensation claim three (3) years prior** to the initial evaluation or **During Treatment.**

5. Have not provided our team with a **Prescription for PT** or referral less than **30 days** old.

6. It is **ILLEGAL** to use your medical insurance when an injury is caused by an auto/bicycle/motorcycle accident or workplace injury.

7. Have not completed your **Coordination of benefits (COB)** letter. Insurers (**BCBS** in particular) may send these COB's during PT treatment or up to **1 YEAR AFTERWARDS.**

*** Auto/Bicycle/Motorcycle Accident claims** and **Workers' compensation claims three (3)** years prior to treatment or **during treatment** must be **CLOSED** before physical therapy at our clinic can continue. ****As of 1/1/2023 we do not accept workers' compensation insurance nor auto accident insurance**.

Initial: _____