Specialized Physical Therapy
Moving You Forward

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Web: www.specialized-pt.com

161 Main Street, North Reading, MA 01864

New Patient Intake Form

Patient Name: _____ Patient Date of Birth: _____ State: _____
Address: _____ # ____ City: _____ Zip Code: _____
VALID Email Address: _____ Phone Number: _____ Sex: M ☐ F ☐
Medical Insurance Carrier: _____ Policy Number: _____
Primary Card Holder: _____ Primary Card Holder Date of Birth: _____
Address Provided Matches State License: Y ☐ N ☐ Insurance Start and End Dates: _____
Copayment amount per visit: _____ Coinsurance %: _____ Deductible Amount Remaining: _____
Is a referral for PT required? Y ☐ N ☐ When is authorization required for PT? _____
Total number of Physical, Speech, and Occupational therapy visits remaining? ____ Is a prescription for PT required? Y ☐ N ☐

Your relationship to Primary Card Holder: _____
Referring Physician: _____ Phone Number: _____
Primary Care Physician: _____ Phone Number: _____

Thank you for choosing Specialized Physical Therapy (**SPT**) for your premium physical therapy needs. We are passionate and committed to providing you and your family with superior Physical Therapy (**PT**) service and look forward to the opportunity of restoring your health to its maximum potential. Please initial the selected paragraphs and sign page two of this document when you have read, agree to, and COMPLETELY understand all of our policies. Cash rates for service will apply if ANY fictitious data are given.

Financial Policy Initial: _____

Specialized Physical Therapy does NOT monitor changes to patient's insurance over the course of treatment as this would be an insurmountable task, and it is the patient's responsibility NOT ours since insurance is a contractual agreement between a patient and their insurance and not between SPT and the patient's insurance. As a courtesy, SPT checks the patient's eligibility and benefits ONE TIME before the initial evaluation and makes no guarantee whatsoever on the accuracy of this information. Insurance unlike cash is a form of payment for our service but it changes constantly. Therefore, if a patient chooses to use insurance rather than cash as payment for our service, that patient is FULLY RESPONSIBLE to know and continuously communicate to us any and all changes in insurance plans, benefits, copays, coinsurances, deductible limits, PIP benefits, plan start and end dates, out of pocket limits, eligibility, deadlines, and PT visits remaining over the course of treatment along with any required authorizations, referrals, and prescriptions. SPT will make a GOOD FAITH effort to submit claims on the patient's behalf to maximize payment. By choosing Specialized Physical Therapy for treatment, the patient or legal guardian agrees to pay in full for service received regardless of payment type. If 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 legal guardian agrees to pay IN FULL for service at our cash rates.

Deductible, Copayment, and Coinsurance Policies Initial: _____

If the patient has a DEDUCTIBLE, $89 IS DUE at the time of the initial evaluation and $49 IS DUE at the time of each follow-up visit. Please note that these are CONSERVATIVE ESTIMATES ONLY and sometimes it takes 30 to 40 days for SPT to receive confirmation from the patient's insurance regarding the actual amount that will be paid for service. An invoice for the true cost of service, actual insurance amount less our estimate collected at the clinic visit will be emailed via PayPal on average every 45 days. In general, expect to pay an additional $10 to $60 more per visit if you have a deductible. If you have a deductible and a Health Savings Account (HSA) please let us know immediately. All COPAYMENTS ARE DUE at the time of the clinic visit. COINSURANCE is typically 10 to 30% of the visit cost and will be invoiced and emailed via PayPal on average every 45 days.

Account Balances, Invoice Late Fees, Returned Checks, and Collection Agency Costs Initial: _____

When a patient chooses to use insurance rather than cash for payment of service, the patient or legal guardian agrees to pay IN FULL for all claims that have been fully or partially rejected, denied, or not paid for ANY REASON. SPT will charge the patient's account at our cash rates if full payment for any reason has not been received within 30 days. Invoices will be sent to patients with account balances. Invoices are due on receipt and all unpaid account balances will accrue a monthly fee at a 21% APR, the current maximum allowable by the State of Massachusetts. All unpaid account balances 60 days past the invoice date will be referred to a collection agency or settled in court. If your account is referred to a COLLECTION AGENCY or court, you will be responsible FOR ALL FEES – not limited to collection agency costs and commissions, and reasonable attorney fees and court costs - associated with that process. A $50 fee will be charged for returned checks and only cash or credit card payments will be acceptable thereafter.

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Initial Evaluation and Reporting of Insurance Changes to SPT Initial: _____

1. Bring an up-to-date insurance card and driver's license to the initial evaluation.
2. Actively monitor ALL changes in insurance *throughout* treatment that could result in rejected, denied, or unpaid claims.
3. Immediately notify us of ANY AND ALL insurance changes as outlined in our financial policy section on page one.
4. Have all PCP REFERRALS, PRESCRIPTIONS, and AUTHORIZATIONS in place BEFORE and DURING treatment if required.
5. A regularly checked email address is REQUIRED: Expect emails from GenBook (no_reply@genbook.com) for appointments; Perfect Fit Health (donotreply@perfectfithealth.com) for exercises and PayPal (service@paypal.com) for invoices.

Cancellation Policy Initial: _____

A cancellation fee of $69 will be charged to a patient's account for each occurrence, after THREE appointments have been cancelled, missed, or rescheduled in any combination. A 24 Hour notice is always appreciated. Please be PUNCTUAL and HONOR your appointment COMMITMENTS to ensure uniform treatment, maintain schedule integrity, and mitigate business losses. This cancellation fee may be increased at any time and without prior notice.

Authorization to Release Information

I authorize Specialized Physical Therapy to release my medical information to my insurance company, physician, attorney, and all other pertinent parties that may be involved in my 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 the practice. 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.

Consent to Treat

I voluntarily consent to evaluation, treatment procedures, and patient care which in the judgment of my therapist or physician may be considered necessary or advisable while a patient at Specialized Physical Therapy. I understand that outpatient therapy is not an exact science and no guarantee has been made as to the result of any treatment or care administered.

Medicare Patients – Must be discharged from Home Health Services 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. If you have received ANY TYPE of home health care services in the past 6 months, you must provide us with documentation stating that you have been fully discharged from the agency that provided these services to you prior to starting treatment at Specialized Physical Therapy.

Notice of Privacy

Federal Laws, The Health Insurance Portability and Accountability Act (HIPAA), and State Laws dictate that we maintain the privacy and security of your medical and health information. This is called Protected Health Information (PHI). HIPAA can be found at http://www.hhs.gov/hipaa and it describes how information about the patient may be used and disclosed and how one can obtain access to this information. When we use or disclose the patient's PHI, we are required to abide by the terms of HIPAA. The patient has the right to request in writing that we restrict how PHI about you is used or disclosed. You agree and acknowledge that you have been offered the opportunity to read HIPAA at our clinic or online and you consent under Massachusetts' Law to the kinds of uses and disclosures of PHI mentioned in HIPAA.

Payment for Service Policy Regardless of Payment Type Initial: _____

By choosing Specialized Physical Therapy for treatment, the patient or legal guardian agrees to pay IN FULL for service received regardless of payment type. If insurance rather than CASH is chosen for payment and claims are fully or partially rejected, denied, or unpaid for ANY REASON, the patient or legal guardian agrees to pay IN FULL for service at our cash rates. Cash rates for our physical therapy service may be changed at ANY TIME and without prior notice.

Patient Name (Print): _____

Parent or Legal Guardian Name (Print): _____

Patient or Parent / Legal Guardian **Signature**: _____ **Date:** _____