Gainesville
Physical Therapy

PATIENT INFORMATION

PLEASE CHECK ONE: ☐ New Patient ☐ Returning Patient ☐ Updating Information

PATIENT'S NAME (FIRST MIDDLELAST):

ADDRESS: EMAIL:

CITY: STATE: ZIP CODE:

Preferred Contact Number: Home**:** Work**:**

Date of Birth: MM/DD/YYYY) Social Security Number (Optional): - -

MARITAL STATUS: (PLEASE CHECK RELEVANT STATUS)

☐ SINGLE SPOUSE'S NAME (F, L)
☐ MARRIED SPOUSE'S DOB: (MM/DD/YYYY)
☐ DIVORCED/WIDOWED

REFERRING PHYSICIAN: HOW DID YOU HEAR ABOUT US:

Emergency Contact: Contact Number:

INSURANCE INFORMATION

PRIMARY INSURANCE: POLICY/ID NUMBER:

NAME OF POLICY HOLDER: DOB: (MM/DD/YYYY)

GROUP/ACCOUNT NUMBER: EMPLOYER:

WORK NUMBER:

SECONDARY INSURANCE: POLICY/ID NUMBER:

NAME OF POLICY HOLDER: DOB: (MM/DD/YYYY)

GROUP/ACCOUNT NUMBER: EMPLOYER:

WORK NUMBER:

COMPLETE IF PATIENT IS A MINOR

GUARDIAN'S NAME: RELATIONSHIP CONTACT'S NUMBER:

I CERTIFY THAT I HAVE READ THE PREVIOUS POLICIES AND HEREBY GIVE CONSENT TO EACH. I UNDERSTAND THAT I MAY REQUEST A COPY OF THIS AGREEMENT AT ANY TIME.

SIGNATURE: ***DATE:***

PRINTED NAME:

Gainesville
Physical Therapy

Consent and Acknowledgement

Consent:
I hereby consent to physical therapy and incidental medical services to be provided by Gainesville Physical Therapy.

Liability:
I understand and agree that Gainesville Physical Therapy will not be responsible for loss or damage to my personal properties or valuables while I am on the premises of Gainesville Physical Therapy.

Release of Information:
I allow Gainesville Physical Therapy to provide information to any third party payors or those hired by the third party payors which may be partially or wholly responsible for payment of my physical therapy bill. I allow Gainesville Physical Therapy. to release information to Practice Care Management Group on my behalf for billing of the said third party payors. I also allow Gainesville Physical Therapy to release my information to the provider or office of provider from which I was referred.

Insurance:
We have an excellent record of getting clients reimbursed for their care. In order to achieve the best possible results for our clients and maintain our industry leading standard of care, Gainesville Physical Therapy expects payment at the time when services are rendered. Patient is fully responsible for knowledge of his/her own insurance benefits and reimbursement policies. **Gainesville Physical Therapy will still submit all the claims to the insurance company on your behalf to ensure maximum you receive maximum reimbursement.**

Automobile Accidents:
We do not bill auto insurance companies. We do not wait for settlement from attorneys or wait for settlement from any automobile carriers. Reimbursement for care can be obtained in the same way that clients are reimbursed from a health insurance carrier.

Durable Medical Equipment(DME) and Supplies:
Some DME and supplies are not reimbursable by insurance companies and must be paid for prior to ordering.

Financial Policy

Thank you for choosing Gainesville Physical Therapy for your physical therapy needs. Please review the following policy regarding financial responsibilities for your care.

Patient Responsibility:

- **All copays, coinsurance, and self-pay balances are due at the time of service.**
- Insurance and Personal information provided must be accurate and up to date.
- **Missed appointments or cancellations less than 24 hours in advance will be charged $50.**
- A $35 fee will be charged for any returned check unpaid by your financial institution.
- **Past due accounts will be charged a delinquency fee of 1.5% per month if left unpaid after 120 beyond the initial billing period Gainesville Physical Therapy reserves the right to submit to a collections agency the balance defaulted on in part or whole 120 days beyond the initial billing period.**

Gainesville
Physical Therapy

Insurance:

We participate in several insurance plans and have verified your physical therapy benefits to the best of our ability at the time requested. It is however your responsibility to be aware of your particular insurance plan's benefits, all deductible amounts, copays, and coinsurances whether in network or out of network. Please be aware that some, and perhaps all, of the services provided may not be completely covered by your insurance company.

☐ Gainesville Physical Therapy is in-network with your insurance company and estimated benefits are as follows:

Deductible Portion Met Portion Remaining

Copay Amount Coinsurance (Estimated Amount)

☐ Gainesville Physical Therapy is out-of-network with your insurance company.

$150 Cost of Initial Visit(Due on the date of service)

$110 Cost of Follow Up Visits (Payment is due each visit)

MEDICARE CAP ACKNOWLEDGEMENT (*SKIP TO THE NEXT SECTION IF YOU DO NOT HAVE MEDICARE)*

The Balanced Budget Act of 1997 instituted an annual Medicare payment cap on outpatient physical, speech, and occupational therapy services. This cap quickly became a problem for many beneficiaries with long term conditions. A moratorium was placed on the cap, and extended through December 31, 2002 by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection act of 2000 (BIPA). The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 place another 2-year moratorium on the Medicare payment cap on outpatient physical, speech, and occupational therapy services. HOWEVER, because no legislation was passed to address the caps prior to the end of 2005, the ***Therapy Payment Caps are in place for 2015. The cap amounts are $1920.00 for physical therapy and speech language pathology combined, and another $1920.00for occupational therapy.***

The $1900.00 equates to 17-20 physical therapy visits per calendar year for Medicare beneficiaries. Most Medicare beneficiaries have a secondary insurance to cover that which is not covered by Medicare. Once the Medicare cap has been reached, the secondary may become the primary and an out-of-pocket co-payment or percentage may apply.

I have read the policy as written above and I agree to the terms and conditions outlined within this policy. Furthermore, I agree to assign all health insurance benefits directly to Gainesville Physical Therapy. I agree to accept full financial responsibility for medical expenses incurred at Gainesville Physical Therapy. I recognize that the terms of this agreement are confidential between myself and Gainesville Physical Therapy.

Print Name Signature Date

Submit Reset