Specialized Physical Therapy
Moving You Forward

T: 978-664-4008
F: 866-949-9835
www.specialized-pt.com
161 Main Street STE 3, North Reading, MA 01864

## SPT New Patient Intake Form – Page 1/4

Patient's Legal Name: ______________________________________________

Legal Address: ______________________________ City: ______________________

Zip Code: ______________ State: ______________ Patient Date of Birth: ______________ Sex: M ☐ F ☐

Valid Email Address: ________________________ Phone Number: ________________________

Primary Health Insurance: ________________________ Member ID #: ________________________

Policyholder (Subscriber) Name: ________________________ Policyholder Date of Birth: ______________

Relationship to the Policyholder: ______________________________________________

Referring Physician: ________________________ Phone Number: ________________________

Primary Care Physician: ________________________ Phone Number: ________________________

Why do you have pain? Fall: ☐ Car Accident: ☐ Work Related: ☐ Sports: ☐ Unknown: ☐ Other: ______________

**Only for patients who have **School** Insurance, **Two** Insurances such as Medicare and BCBS, or who have been in an **Auto** or **Workplace** Accident.*

*Secondary Health Insurance: ________________________ Policy Number: ________________________

*Prep School / College Health Insurance Name: ______________________ Policy Number: ______________________

*Auto Accident/Workers' Comp. Insurance: ______________________ Adjuster Name: ______________________

*Adjuster Phone: ______________ Claim Number: ______________ PIP Application Completed: Y ☐ N ☐

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** pages three and four 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.

**Deductible, Copayment, Coinsurance, and Invoice Policies** Initial: _______

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. Copayments, Deductibles, Coinsurances, and Self-Pay Payments, are **due at the time of service**; invoices are **due on receipt**. If a patient's insurance plan includes a deductible, **$89** is due at the time of the initial evaluation and **$49** is due at the time of each subsequent treatment. Please note that these are CONSERVATIVE ESTIMATES only. On occasion, it may take up to 30 to 60 days for SPT to receive *explanation of payment* (**EOP**) from the patient's insurer confirming the actual amount that will be paid for treatment. In general, expect to pay an ADDITIONAL and *ESTIMATED* **$25** (follow-ups) to **$60** (initial evaluation) more per treatment if you have an insurance deductible. If you have a Health Savings Account (HSA) or Health Reimbursement Account (HRA) and a deductible, please advise us immediately. Coinsurance is typically 10% to 40% of the treatment cost will be due at the time of service or invoiced. Invoices will be emailed to those patients with account balances via PayPal every 30 to 60 days on average. The patient is always responsible for applicable copayments, coinsurances, deductibles, etc. as determined by their insurer.

Specialized Physical Therapy
Moving You Forward
T: 978-664-4008
F: 866-949-9835
www.specialized-pt.com
161 Main Street STE 3, North Reading, MA 01864

# SPT New Patient Intake Form – Page 2/4

**SPT Financial Policy and Patient Obligations** Initial: _______

Please understand that 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 refuses to pay your claim in full for any reason, refuses to cover a certain treatment, or otherwise fails to pay us, your contract with us still exists, and you are responsible for payment personally.

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. As a courtesy, SPT will make reasonable efforts to confirm the patient's eligibility and benefits before the initial evaluation; however, SPT does not guarantee the accuracy of any information obtained and verification of a patient's eligibility and benefits is **no guarantee of payment**. Over the course of treatment, the patient is obligated to MONITOR and immediately NOTIFY our clinic (preferably in writing) in a TIMELY manner of any and all any changes, modifications and/or amendments to the terms of the patient's insurance plan, including but not limited to eligibility, benefits, copays, deductibles, end dates, start dates, and remaining PT visits. The patient is responsible for ensuring that all insurance requirements such as, but not limited to, authorizations, referrals, applications (i.e. PIP), medical necessity reports, and PT prescriptions are **active**, **valid**, and **accurate prior to and throughout** treatment. SPT will make reasonable efforts to submit requisite medical necessity reports, prior-authorizations, and claims to the patient's insurance; however, after the claim filing deadline has passed, SPT **will not** pursue claim appeals and will invoice the patient for any and all unpaid account balances. 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.

**Policy Changes** Initial: _______

SPT reserves the right to make policy, service rate, and cancellation fee changes ANYTIME and WITHOUT PRIOR NOTICE; they will be effective immediately when posted on our website, at our clinic, or emailed by our appointment scheduling system.

**Account Balances, Returned Checks, Invoice Late Fees, and Collection/Legal Fees** Initial: _______

A thirty ($30) dollar fee will be charged for returned checks and only cash or credit card payments will be acceptable thereafter. Invoices are due on receipt and all unpaid account balances will accrue a monthly fee at the rate of **1.5%** per month or **18%** per year. Any account balances that remain *unpaid thirty (30) days past the invoice due* date may be referred to COLLECTIONS. If a patient fails to make full payment thirty (30) days past due, SPT may at any time, without notice or demand, institute proceedings to enforce the terms of this agreement and collect the unpaid balance of the account and should the terms of this agreement be enforced, the patient or parent/legal guardian agrees to reimburse SPT the fees of any collection agency, which may be based on a percentage at a *maximum of thirty percent (**30%**) of the debt*, and all costs and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

**Your First Appointment and Email Notifications** Initial: _______

1. Bring a valid insurance card, a valid Driver's License or ID card, and money for out-of-pocket expenses; dress appropriately.
2. Expect emails from Genbook (no_reply@genbook.com) for appointment confirmations and **24-Hour** reminders, Perfect Fit Health (donotreply@perfectfithealth.com) for exercises, and PayPal (service@paypal.com) for invoices.

**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 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, or symptoms you may experience from massage creams and lotions, instrument gels and fluids, latex exercise bands, cleaners, and disinfectants.

Specialized Physical Therapy
Moving You Forward

T: 978-664-4008
F: 866-949-9835
www.specialized-pt.com
161 Main Street STE 3, North Reading, MA 01864

## SPT New Patient Intake Form – Page 3/4

**No Guarantees:** 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: Must be FULLY discharged from Home Health Services BEFORE starting outpatient PT** 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 six (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 SPT.

**Notice of Privacy Practices: Located on our Website 24/7 and in our Clinic** 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 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 insurance (i.e. health, auto, or workers' compensation) 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**: ___________________________ **Date:** ______________

Specialized Physical Therapy
Moving You Forward

T: 978-664-4008
F: 866-949-9835
www.specialized-pt.com
161 Main Street STE 3, North Reading, MA 01864

## SPT New Patient Intake Form – Page 4/4

## CANCELLATION POLICY – Please Read Carefully

Welcome to our practice and thank you for choosing Specialized Physical Therapy, **SPT**, for your premium physical therapy services. We are passionate about our practice and committed to providing you and your family with the highest quality of care. We understand emergencies may occur and will take them under careful consideration. However, in order to treat all patients fairly and equally and to provide a premium physical therapy service to our patients, we urge all patients to be punctual and **HONOR** their appointment commitments since it's crucial to *each* patient's care and recovery. Furthermore, frequently missing appointments can hamper your recovery and turn a simple injury into a **more serious and costly chronic problem**. Restoring your health to its maximum potential is only possible when you show up on time for *each* of your scheduled appointments. *When you schedule an appointment with SPT you make a commitment to your health; in turn, we guarantee that time is reserved solely for you and no one else.*

**POLICY LOCATION AND CHANGES**

- Located online at our Patient Forms webpage 24/7: http://www.specialized-pt.com/ and click on the 'Patient Forms' button.
- Located at our clinics reception's desk and on the wall by the waiting area (Abridged Policy).
- Located on *each* and *every* appointment confirmation and **24-HOUR** Appointment Reminder **emailed** automatically sent via **Genbook**, our appointment scheduling program (Abridged Policy).
- SPT reserves the right to make policy, service rate, and cancellation fee changes ANYTIME and WITHOUT PRIOR NOTICE; they will be effective immediately when posted on our website, at our clinic, or emailed by our appointment scheduling system.

**CANCELLATION/RESCHEDULE/NO-SHOW POLICY:**

- **FIFTY DOLLAR ($50) FEE:** Failing to show up ("NO SHOW") to a scheduled appointment with your Physical Therapist.
- **FIFTY DOLLAR ($50) FEE:** Canceling or rescheduling a scheduled appointment without giving us **AT LEAST 24 HOURS NOTICE**.
- **FIFTY DOLLAR ($50) FEE:** Arriving 15 minutes late or more to **ANY** scheduled appointment.
- **FIFTY DOLLAR ($50) FEE:** **Frequently** rescheduling **same day** appointments and/or **appointments** greater than 24 hours.
- This cancellation fee is not covered by insurance or any third-party payers, and will have to be paid by you personally.
- All invoices sent by SPT, for fees incurred and account balances, are **due on receipt**. Additionally, service will be denied if payment is not received **BEFORE** the next scheduled appointment.
- SPT reserves the right to **DISCHARGE PATIENTS** and close their account at ANY TIME for tardiness, absence, reschedules, cancellations, disrespect, and bad behavior.
- Patients are scheduled one appointment at a time on a first come, first served basis and on medical necessity
- **24-HOUR REMINDERS** will be automatically sent via text and email (by Genbook (no_reply@genbook.com)) to help remind patients of their upcoming appointments. If you are not receiving these reminders, please let us know.
- Canceled appointments and NO SHOWS 1) slows your recovery time, 2) hampers the health of a patient that could have used your appointment time, and 3) wastes the expertise and talent of our dedicated Physical Therapists – it's a no win situation.
- Cancellations and no shows will be documented in your medical record and made available to your PCP and third party payers.
- Initial Evaluations are **60 minutes** in length; follow-up treatments are **30 minutes** in length.
- It is the patient's responsibility to know when the appointment is, to check with the clinic if needed, and to be punctual.
- We value our patient's time so please value ours.

By signing your name on page four of this document and choosing SPT 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.

**Thank you for choosing Specialized Physical Therapy!**

**PATIENT NAME** (*Print or Type*): ____________________________________________

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

PATIENT or PARENT / LEGAL GUARDIAN **SIGNATURE**: ____________________________ **Date:** ______________