Tel: 561/498-1423 Fax: 561/498-7848
4800 Linton Boulevard, Suite F116
Delray Beach, Florida 33445
www.ptinstitute.com

PPO/HMO/SELF PAY 2021

PATIENT REGISTRATION PROCEDURE

Welcome to our Practice,

We know your time is valuable and we strive hard to begin and end our treatment sessions timely. As a new patient we have several forms for you to fill out. If you would like to fill these forms out before you come in for your evaluation and treatment, please print out this packet of necessary forms for billing your insurance company. Fill them out as best you can and we will help you with any information that you cannot provide when you come in for your appointment. The packet includes:

PATIENT INFORMATION

FINANCIAL POLICY

PATIENT RECORD OF DISCLOSURES

PATIENT INFORMATION ACKNOWLEDGMENT FORM

NOTICE OF PATIENT INFORMATION PRACTICES

MEDICATION LIST

If you prefer to fill out our new patient forms in our office, please come to our office 15 minutes before your scheduled appointment time. Please wear comfortable clothing and bring shorts to change into if we are treating your lower extremity. Please also bring with you your prescription for therapy services and your insurance card (if you would like us to bill your insurance company on your behalf).

We look forward to being your provider of choice and exceeding your expectations!!!

THANK YOU,

The Staff of Physical Therapy Institute, Inc.

PATIENT INFORMATION
HMO/PP0/SELF PAY

PATIENT:			EMAIL:
ADDRESS:		CITY:	ZIP:
Home#	Cell#	Work#	Email:
Date of Birth:		Social Security #:	

EMPLOYMENT STATUS:
FULL TIME: _______ PART TIME: ________ RETIRED: ________

EMPLOYER:		
Employer Address:	City:	Zip:
REFERRED BY DR:	NEXT MD APPOINTMENT:	

PRIMARY INSURANCE CARRIER INFO: Unnecessary to include numbers if we copied your insurance cards!

INSURANCE CARRIER: ______________________________

NAME OF INSURED: ______________________________

POLICY NUMBER: ____________________ PHONE #: ____________________

______Initials I hereby consent to physical therapy treatment provided to me by Physical Therapy Institute, Inc. as referred by my physician.

______Initials I understand and agree that I am personally responsible for all fees for services rendered by PT Institute, Inc. to me regardless of what my insurance covers inclusive of cost of collection.

______Initials I understand that it is my responsibility to inform Physical Therapy Institute, Inc. if there is a change in my insurance coverage.

______Initials I understand that Physical Therapy Institute, Inc. does not bill secondary insurance carriers.

______Initials I understand that I am responsible for my copayment (if applicable upon services rendered).

______Initials Your insurance company may send payment directly to the patient. If I receive a check in error, I understand it is my responsibility to forward that check (or a personal check in that same amount) to Physical Therapy Institute, Inc. so that my account can be credited properly.

______Initials I hereby authorize assignment of payment of all insurance benefits to the provider of service.

______Initials I authorize the release of any medical information necessary to process this claim.

______________________________ ______________________
Signature of Patient Date

______________________________ ______________________
Signature of Witness Date

FINANCIAL POLICY - PRIVATE INSURANCE

We have found that communication with our patients regarding our financial policy assists us in providing the best service to you. If you have any questions, please do not hesitate to discuss them with us.

Insurance Verification:
As a courtesy to you the insured, Physical Therapy Institute, Inc. verifies insurance benefits and coverage at the time you begin our professional services. This verification is only an estimation of insurance benefits at the time of verification and in no way a promise on behalf of the insurance company to pay for any services rendered. The patient, or legal guardian, is liable for all charges not covered by insurance, whether or not such coverage agrees with the estimated amount. The patient, or legal guardian, is also responsible for charges if the insurance carrier denies the claim or deems that the treatment provided is not medically necessary. It is advisable for the patient to confirm that your policy will cover services rendered and to know if limitations apply as well as your outstanding
deductibles. Furthermore, I understand that if my insurance carrier or coverage changes at any time, I am responsible for immediately providing that information, as well as a copy of the insurance card, to Physical Therapy Institute, Inc. As with any change in insurance, I understand that I am responsible for any charges that are not covered by my insurance carrier as well as deductibles not yet met. ________(initial) At each visit, you will be asked to pay your estimated portion (copayment and/or deductible) for the treatment. For your convenience we accept VISA, MASTERCARD AND AMERICAN EXPRESS.

Cancellation Policy:
We would greatly appreciate 24 hours notice if you are unable to keep your scheduled appointment. When our office is closed, you may cancel an appointment by leaving a message on our voice mail. Appointments cancelled for non-emergency reasons with less than 24 hours notice may be subject to a $30.00 cancellation fee. Arrival more than 15 minutes after the time of your scheduled appointment may be considered a failed appointment.

Authorization:
I hereby authorize Physical Therapy Institute, Inc. to provide professional services to me/my child/my legal ward. I understand that I am financially responsible for all fees incurred for my/my child's/my legal ward's treatment, even if I have insurance which covers all or part of the cost of the treatment.

I hereby authorize Physical Therapy Institute, Inc. to furnish my insurance carrier(s) any and all requested information concerning my health care. I also authorize my insurance carrier(s) to pay Physical Therapy Institute, Inc. directly for any services rendered.

Patient's Name:________________________________ Date:________________________

Signature:____

(Patient or Legal Guardian)

Revised 12/31/2020

Payment Policy:
I understand and agree that I am totally responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand. I understand that insurance claim forms will be submitted to my insurance company as a courtesy only and that I am primarily responsible for all charges regardless of any existing medical coverage. I understand that verification and authorization of insurance benefits are not a guarantee for payment by my insurance company. It is my responsibility to thoroughly understand my health insurance coverage, it's policy limitations, exclusions and changes. I further understand that Physical Therapy Institute, Inc. cannot accept the final responsibility for collection on insurance or negotiating a settlement on a legal case. There will be a service fee assessed to you for each returned check in the amount of $30.00. Should a returned check not be able to be re-deposited, another form of payment will be required including the service fee.

In the event my insurance company forwards payment directly to me, instead of to Physical Therapy Institute, Inc., I will immediately deliver such payment to Physical Therapy Institute, Inc. I understand and agree that if it becomes necessary to commence legal action for the collection of any outstanding charges on my account, I will be responsible for any costs and court costs, in addition to the outstanding balance.

Patient's Name:________________________________ Date:________________________

Signature:____
(Patient or Legal Guardian)

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If you would like us to, we can automatically apply your portion of the bill to your Visa, MasterCard or American Express.

I hereby authorize: Physical Therapy Institute, Inc.
4800 Linton Blvd., Suite F116
Delray Beach, Florida 33445

to apply my balance to my charge card account.

_____ Visa _____MasterCard _____American Express

Account Number: ________________________________ Expires:________________________
(Must be 20 digits)

____Date:________________________
Cardholder's Signature

Physical Therapy Institute, Inc.

PATIENT INFORMATION ACKNOWLEDGMENT FORM

I have read and fully understand Physical Therapy Institute, Inc.'s Notice of Information Practices. I understand that Physical Therapy Institute, Inc. May use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. 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 also understand that Physical Therapy Institute, Inc. will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge the use and disclosure of m personal health information for purposes as noted in Physical Therapy Institute, Inc.'s Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

____

Patient Name

____

Signature

____

Date

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

PHYSICAL THERAPY INSTITUTE's LEGAL DUTY

Physical Therapy Institute, Inc. is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Physical Therapy Institute, Inc. uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, ***Physical Therapy Institute Inc.,*** may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Physical Therapy Institute, Inc., may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, ***Physical Therapy Institute Inc.'s*** policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Physical Therapy Institute, Inc. may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Physical Therapy Institute, Inc. will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that ***Physical Therapy Institute, Inc.*** may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on ***Physical Therapy Institute Inc. 's*** health information practices or if you have a complaint, please contact the following person:

Physical Therapy Institute, Inc.

Linda J. Zane, MPA, PT, Owner

4800 Linton Blvd., Suite F116

Telephone: (561)496-1446 Fax Number: (561)498-7848