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

MEDICARE 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.

TO OUR MEDICARE PATIENTS: JANUARY 2021

Please be advised that we are a Medicare Part B participating provider. What this means is that we accept Medicare's fee schedule as payment for our services. About 15 days after we submit your bills, First Coast Service Organization/Medicare will reimburse us directly for 80% of their fee schedule. You are responsible for the remaining 20% plus your 2021 deductible of $203.00. ***Under no circumstances do we waive your deductible or copayment as it is considered as fraud by the federal government.***

If your secondary carrier is a participant of Medicare's Medigap Program, Medicare will automatically file your secondary insurance. **Should your secondary carrier not be a participant of Medicare's Medigap program, we will routinely collect your copayment at the time of your appointment. We will collect $20.00 per visit as an approximation of your 20% copayment**. Any difference between what we collect and what your final copayment is will be reconciled when we receive our final payment from Medicare.

Remember, for Medicare to pay for your treatments, you have to meet the following criteria:

▯	Your present treatment plan **must have nothing to do with an automobile accident, legal case or be covered by your employer's medical policy.**
▯	**You must be discharged from any home health care services** prior to initiating outpatient physical therapy. Medicare will not pay for both home health care and outpatient care at the same time.
▯	If you initiated physical therapy with **an out of state prescription**, you must present this office with a Florida MD prescription within 30 days of your first visit in order to be in compliance with our Florida Physical Therapy license.
▯	The benefits in the Part B program have changed. ***It now specifies that there is no hard dollar limitation for outpatient physical therapy per calendar year***. However, if your condition necessitates you exceeding $3000 of therapy per calendar, ***we may be required to clearly document and justify medical necessity if requested by Medicare. If we feel that you do not meet the threshold of medical necessity past $3000 we will notify you and we can arrange an extremely discounted fixed visit rate to encourage you to continue to receive therapy at our facility.***
▯	It is your responsibility to notify this office if you have received therapy during this calendar year at any other facility or if you have had home health.

I acknowledge that I have read the above policy, and I understand that I am responsible for my 20% copayment, any deductible not met, and for notifying Physical Therapy Institute, Inc. if I have not met the above-mentioned criteria.

______________________________ ____________________

Signature of Patient **Date**

We truly appreciate the opportunity to meet your physical therapy needs. Let us know if there is anything more we can do for you!!

The Owners, Linda J. Zane, MPA, PT and Ira M. Fiebert, PHD, PT

MEDICARE

PATIENT:			EMAIL:
LOCAL ADDRESS:		CITY:	ZIP:
PERMANENT ADDRESS: (for insurance)		CITY:	ZIP:
HOME #:	CELL #:		WORK #:
DATE OF BIRTH:			

EMPLOYMENT STATUS:

FULL TIME _____ PART TIME: _____ RETIRED: _____

EMPLOYER:

REFERRED BY DR:	NEXT MD APPOINTMENT:

HAVE YOU RECEIVED PHYSICAL OR SPEECH THERAPY ELSEWHERE IN 2021?

____ YES _____ NO __

IF YES, WHERE? ____

If this injury covered by Auto Insurance, Employer's Insurance or a Legal Case? YES _____ NO _____

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

INSURANCE CARRIER: ____

NAME OF INSURED: ____ DOB: _______________

POLICY NUMBER: ____

_______ Initials I hereby consent to physical therapy treatment provided to me by Physical Therapy Institute, Inc. as prescribed 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.

_______ Initials I understand that Physical Therapy Institute, Inc. only bills secondary insurance carriers that participate in the Medigap Program.

_______ Initials I understand that if my secondary carrier does not participate in the Medigap Program, or they pay me directly, I am responsible for paying my copayment at each appointment.

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

____ Signature of Patient ________________________ Date

____ Signature of Witness ________________________ Date

Disclaimer for Medicare Patients
Prior Therapy Services During 2021

Have you received any Physical Therapy or Speech Therapy Services in any State or any type of therapy facility during this year?

For Example: ***Outpatient Hospital Department, MD office, Corporate Rehab Company or another private therapy office***

YES ____	NO ____

If yes, last date of service: ______________________________

Name of Provider: ______________________________

Phone number of Provider: ______________________________

If you answered YES, I hereby authorize my previous speech or physical therapist to release to Physical Therapy Institute, Inc. a copy of all pertinent information to assist in the transfer of billing to this office.

If you answered NO, please be sure to circle no and sign below:

______________________________ ______________

Signature of Patient Date

______________________________ ______________

Witness Date

==

For Office Use Only

- ☐ Called Therapist to Confirm Discharge Date
- ☐ Confirmed how much money used towards cap ____________
- ☐ Spoke to ______________________ at ______________
  Name Time
- ☐ Patient discharged ______________
  Date
- ☐ Patient will be discharged
- ☐ Confirmed with First Coast

____

Date Name Reference Number

Disclaimer for Medicare Patients
Home Health Services

Have you had Health Care Services provided in your HOME in the last 60 days for ANYTHING?

For Example: ***Therapy, Wound Care, Diabetic Care, etc.***

YES ____	NO ____

If yes, last date of service: ______________________________

Name of Agency: ______________________________

Phone number of Agency: ______________________________

If you HAD Home Health Services, I hereby authorize my home healthcare agency to release to Physical Therapy Institute, Inc. a copy of my Discharge Summary along with a copy of the Discharge paperwork that they sent to Medicare and sign below:

If you HAVE NOT had Home Health Services, be sure to circle NO and sign below:

______________________________ ______________

Signature of Patient Date

______________________________ ______________

Witness Date

==

<u>For Office Use Only</u>

- ☐ Called Home Health Agency to Confirm Discharge Date
- ☐ Spoke to ____________________ at __________
  Name Time
- ☐ Patient discharged ______________
  Date
- ☐ Patient will be discharged
- ☐ Confirmed with First Coast

____

Date Name Reference Number

FINANCIAL POLICY

Medicare

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.

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.

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Authorization to Treat: I hereby authorize Physical Therapy Institute, Inc. to provide professional services to me.

Patient's Name:______________________________ Date:__________________

Signature: ____

(Patient or Legal Guardian)

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Assignment of Benefits: I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf to Physical Therapy Institute, Inc. This authorization shall apply to the period __________________ to __________________ .

Patient's Name:______________________________ Date:__________________

Signature: ____

(Patient or Legal Guardian)

FINANCIAL POLICY- PRIVATE INSURANCE
Page Two

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, its 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: ____

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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: ____________________

____ Date: ____________________
Cardholder's Signature

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

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 my 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

f 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

My Medication List

Keep this medication list in your wallet or purse.
Share it with your doctors, pharmacist, and other health care professionals at ALL visits

Personal Information		**Allergies to Medicine**	
Name:		Allergic To	Describe Reaction
Address:			
Birth Date:			
Primary Care Physician	Name:	Phone #:	

List all medicine you are currently taking: Prescription and over the counter medications (examples: aspirin, antacids) and dietary supplements (example: vitamins) and herbals (examples: ginseng, gingko). Include medications taken as needed (examples: inhalers, nitroglycerin).

Prescription Medication Name	**Dose (How much)**	**Frequency (How often)**
Over-the-counter Medications /Vitamins/Herbals		
Name of Medication	**Dose (How much)**	**Frequency (How often)**

Medication List Completed or Updated (Date): ____________________ Page ______ of ________