

Dear New Patient:

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 one of each of the following:

PATIENT INFORMATION

FINANCIAL POLICY -We break these out into four categories...Medicare, Workers' Compensation, Motor Vehicle Accident and PPO/HMO/Self Pay.

PATIENT RECORD OF DISCLOSURES

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

PATIENT RIGHTS AND ACKNOWLEDGEMENT FORM

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).

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 2007

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 30 days after we submit your bills, First Coast/Medicare will reimburse us directly for 80% of their fee schedule. You are responsible for the remaining 20% plus your 2006 deductible of \$131.00. ***Under no circumstances do we waive your deductible or copayment as it is considered by the federal government as fraud.***

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 \$15.00 per visit as an approximation of your 20% copayment.** A receipt will be provided to enable you to personally submit to your secondary insurance carrier once you receive your Explanation of Benefits (EOB) from Medicare. 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:

1. Your present treatment plan **must have nothing to do with an automobile accident, legal case or be covered by your employer's medical policy.**
2. **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.
3. If you initiated physical therapy with a **an out of state prescription**, you must present this office with a Florida MD prescription within 21 days of your first visit in order to be in compliance with our Florida Physical Therapy License.
4. The benefits in the Part B program have changed. It now specifies that there is a \$1740. limitation for outpatient physical therapy per calendar year in all settings except the hospital rehabilitation department. This translates to approximately 21 visits at PTI.. ***If your condition requires care beyond \$1740, there is an exemption process that we can initiate with Medicare if we can clearly document medical necessity or we can arrange an extremely discounted fixed visit rate to encourage you to continue at our facility.***
5. It is your responsibility to notify this office if you have received therapy during this calendar year at any other facility.

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: _____

ADDRESS: _____ CITY: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____

BIRTHDAY: _____ SOCIAL SECURITY NUMBER: _____

MARITAL STATUS: SINGLE _____ MARRIED _____ OTHER _____

EMPLOYMENT STATUS: FULL TIME _____ PART TIME _____ RETIRED _____

EMPLOYER: _____

ADDRESS: _____

REFERRED BY DR.: _____ NEXT M.D. APPOINTMENT: _____

HAVE YOU RECEIVED PHYSICAL THERAPY OR SPEECH THERAPY ELSEWHERE IN 2007? YES _____ NO _____

If yes, where?

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

SECONDARY INSURANCE CARRIER INFO:

INSURANCE CARRIER: _____

NAME OF INSURED: _____

POLICY NUMBER: _____

Unnecessary to put numbers if we photocopied your insurance cards!!

- P I hereby consent to physical therapy treatment provided to me by Physical Therapy Institute, Inc. as prescribed by my physician.
P I understand and agree that I am personally responsible for all fees for services rendered by Physical Therapy Institute, Inc. to me or my dependents regardless of what my insurance covers.
P I understand that Physical Therapy Institute, Inc. only bills secondary insurance carriers that participate in the Medigap Program.
P 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.
P I authorize the release of any medical information necessary to process this claim.

Signature of patient

Date

Witness

Date

Disclaimer for Medicare Patients

Have you had any Health Care Services provided in your HOME in the last 60 days? I.E. Therapy, Wound Care, Diabetic Care, etc.

YES

NO

If yes, last date of service: _____

Name of agency: _____

Telephone 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.

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

Signature of patient

Date

Witness

Date

=====

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For Office Use Only

Q Called Home Health Agency to Confirm Discharge Date

Q Spoke to _____ at _____
Name Time

Q Patient discharged _____
Date

Q Patient will be discharged

Q Confirmed With First Coast

Date	Name	Reference Number
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C:\Documents and Settings\LINDA ZANE\My Documents\WebsitePaperworkMedicare.wpd

Disclaimer for Medicare Patients

Have you received any Physical Therapy or Speech Therapy Services in any state during this year ?

YES

NO

If yes, last date of service: _____

Name of Provider: _____

Telephone 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

Q Called Therapist to Confirm Discharge Date and how much money used towards cap

Q Spoke to _____ at _____
Name Time

Q Patient discharged _____
Date

Q Patient will be discharged

Q Confirmed With First Coast

Date	Name	Reference Number
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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.

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)

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)

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

I authorize Physical Therapy Institute, Inc. or its assigns to contact me by using the email address listed below. I have received a copy of Physical Therapy Institute, Inc.'s "E-mail Confidentiality Notice" dated 11/1/06. If I wish to discontinue getting emails from Physical Therapy Institute, Inc., I will revoke this authorization in writing.

I understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

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