TSA Physical Therapy

Patient Information Form

Patient Information

Last Name ________ First Name ________ MI ____ SSN

Address ________

Address2 ________ City ________ State ____ Zip ________

Home Phone ________ Work Phone ________ Cell Phone ________

Date of Birth ________ Gender ____ Marital Status ________ Email ________

Emergency Contact

Last Name ________ Relationship ________

First Name ________ Phone ________

Employer

Name ________ Phone ________

Address ________

Address2 ________ City ________ State ____ Zip ________

Problem

Problem Description ________ Date of Injury ________ Last Physician Visit / / ________

Referred By ________

Latest Referral Information ________ Motor Vehicle Accident ____

Latest Plan of Care ________ That occurred in: ____

Notes: ________

Primary Insurance

Insurance ________ Deductible ________

ID ________ Max Benefit ________

Group # ________ CoPay ____ CoInsurance ________

Subscriber

Name ________

Relationship ________

Date of Birth ________

Secondary Insurance

Insurance ________ Deductible ________

ID ________ Max Benefit ________

Group # ________ CoPay ____ CoInsurance ________

Subscriber

Name ________

Relationship ________

Date of Birth ________

Tertiary Insurance

Insurance ________ Deductible ________

ID ________ Max Benefit ________

Group # ________ CoPay ____ CoInsurance ________

Subscriber

Name ________

Relationship ________

Date of Birth ________

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the Patient Registration form.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

(You have the right to refuse to sign this acknowledgement if you so choose.)

Signature:________ Date:________

Please review, edit or complete *(USING BLACK INK ONLY)* all information below.

*** We do not call to remind you of your appointments this service is available by text or email only***

☐ **Yes! I would like appointment reminders sent to me:**

Email me at: ______________________________

Text me at: (_____)__________________ **Cell phone Carrier:**__________________

I Authorize TSA PHYSICAL THERAPY, PC to discuss my medical information with the following:

Spouse:	Phone #:
Family Member:	Phone #:
Referring Doctor:	Phone #:
Doctor other than Referring/Primary Care:	Phone #:
Attorney:	Phone #:
Other (relationship):	
I authorize TSAPT to leave a message regarding ***my physical therapy*** on my answering machine/voicemail. ☐ YES ☐ NO	
I authorize TSAPT to leave a message regarding ***my appointments*** on my answering machine/voicemail. ☐ YES ☐ NO	

How did you hear about TSAPT?

____

Patient name: ______________________________ **Date** ___/___/____

Reason (s) for attending physical therapy:	Date of Onset: Date of Surgery:
Primary Care Doctor: Date of last appointment:	Referring Doctor: Date of Next Dr Appointment:

Are you taking any medications now? ❑YES ❑NO If YES please list below or attach list:

MEDICATION	REASON FOR TAKING MEDICATION

Height ______________ **Weight** ______________

Do you have now, or have you ever had, any of the following conditions?
Please check all that apply.

CONDITION	YES	NO	CONDITION	YES	NO
Are you pregnant NOW?	❑	❑	Diabetes: TYPE 1 / TYPE 2	❑	❑
Electronic implant (s) ____	❑	❑	Osteoporosis	❑	❑
Pacemaker	❑	❑	Osteoarthritis	❑	❑
Rheumatoid Arthritis	❑	❑	Heart problems	❑	❑
High blood pressure	❑	❑	Cancer	❑	❑
Asthma	❑	❑	Other (please explain):	❑	❑
Seizures	❑	❑			

Are you __currently__ receiving **chiropractic, occupational, physical or speech therapy**?
❑YES ❑NO

If ***YES, where*** and for what injury?

Last date of service:

Have you had any ***physical therapy, occupational therapy , or speech therapy*** anywhere ***other than TSAPT this year***?

❑YES ❑NO

If ***YES*, *where*** did you receive this care?

Last date of service:

Type of insurance to be billed for this injury:

❑ **Private Insurance**

❑ **Workers Compensation**

❑ **No Fault**

❑ **Third Party** (***we do not participate with third party insurance, you will be responsible for billing them yourself)***

Date of Injury/accident:

If this is a ***No Fault*** or ***Workers' comp*** case have you had **PT for *this case* before**:

❑YES ❑NO

If *yes*, where have you had **PT**:

Employer at time of injury:	**Employer address:**
	Phone number:
Adjuster name:	**Adjuster phone number:**

TSAPT : Office & Financial Policies

Appointments

- Appointments are available Monday - Friday 8:00am - 6:00pm. The front desk in the main office is available to schedule appointments from 8:00am - 5:00pm Monday - Friday.
- Appointments are not automatically scheduled and must be booked by the patient; there are no "standing appointments". To ensure you receive appointments that best fit into your schedule, book them at least 48 hours in advance.
- A print out of your scheduled appointments is available. As you are responsible for any missed appointment, we recommend you review & retain the printout of your scheduled appointments in the event of a scheduling error.
- Arrive 10 minutes early for each appointment. Upon arrival for your appointment, sign in at the front desk, make copay/coinsurance payment and schedule any additional appointments.

No Show/Cancellation Policy

- If you fail to make your scheduled appointment and do not notify our office 12 hours prior to the scheduled time of your appointment, you may be charged a fee of $25.00 per missed appointment. This fee must be paid prior to the start of the next appointment. We reserve the right to charge you for overly missed appointments. Overly missed appointment includes No show, and Cancelled appointments with or without notice. A patient who misses three (3) appointments may be discharged

Prescriptions

- Prescriptions expire one (1) month from the date they were written. Patients are responsible for maintaining a valid prescription & for requesting an updated prescription from their doctor every thirty (30) days. The patient will be responsible for any visits not covered by their insurance because a valid prescription was not obtained.
- Direct Access: Some insurance companies honor the New York State law of Direct Access. Under Direct Access a patient may seek physical therapy services without a doctor's prescription for ten (10) visits or thirty (30) days, whichever comes first. Please speak with a front desk associate for additional information.

HIPAA

- TSAPT's HIPAA policy is posted in the waiting area, a copy of this policy is available upon request. TSAPT will make all reasonable attempts to follow HIPAA policy. Due to the open environment of the physical therapy treatment area and therapy gym area, patient waives HIPAA liability in those areas of the office.

Evaluations/Re-Evaluations

- Any new diagnosis will be treated only after a thorough evaluation.
- After a lapse in therapy greater than 30 days, a patient will be evaluated as conditions change over time.
- Re-Evaluations are required by both insurance companies and doctors. They will be done every 30 days and submitted to the referring doctor and primary care if listed.

Copays/Insurance Benefits

- TSAPT provides patients with an outline of their insurance benefits. This information is provided as a courtesy and is based on the information provided by the patients insurance company's customer service representative. It is the patients responsibility to know their insurance benefits, including but not limited to copy/coinsurance, deductible, referrals and visit limits.
- **All copays and coinsurance payments are due at the time of each appointment. (If 3 appointment payments are due patient may not be seen until payment is made.)**
- **Any balance not paid at the time of service will be billed; any balance unpaid after thirty (30) days are subject to a finance charge. The patient may not be permitted to schedule appointments until balances over 30 days are paid in full.**
- The patient is responsible for notifying the front desk of any changes in insurance, address or phone numbers.

TSAPT: Office & Financial Policies Agreement and Authorization

Patient or Guardian Agreement:

I authorize release of information requested by my insurance plan for payment.
I understand payment is due at the time of service and I am responsible for any balance due.
I agree to comply with the terms and conditions as outlined in the *Office & Financial Policies*.
I hereby acknowledge and agree to TSAPT HIPAA policies.

I hereby assign all medical benefits, to which I am entitled, including Medicare Part B, private insurance, private Medicare, major medical and any other plan to TSA PHYSICAL THERAPY, PC (TSAPT). I understand I am responsible for providing all of my insurance information and notice of any changes to that information that may take place. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be consider as valid as an original.

In 2020, Medicare Part B covers outpatient therapy at 80% of the Medicare-approved amount ($2,080). This means Medicare Part B covers up to $1,664 (80% of $2,080) before your provider is required to confirm that your therapy is medically necessary. When you receive services from a participating provider, you pay a 20% co-insurance after you meet you Part B deductible ($198 in 2020).

I understand that I am responsible for all charges whether or not paid by said insurance. I understand that TSAPT cannot estimate the level of reimbursement by my insurance carrier due to the number of plans and variety of contracts within each plan. We (TSAPT) recommend that you check with your own insurance company about reimbursement and the need for prior authorization before having Physical Therapy. I understand copay/coinsurance is due at the time of service and additional balances will be billed to me. I understand it is possible that my fee for service may be different than the copay/coinsurance amount provided to me a s courtesy by TSAPT. I understand that it is my responsibility to know the balance of my deductible (if applicable) and to notify TSAPT when that has been met and, until that time, I will be responsible for paying my copay/coinsurance at the time of service. I also agree to pay any and all attorneys and/or collection fees of a reasonable amount on the unpaid balance, if this account is referred to collection. I certify that the information given to me in applying for payment under title XVIII of Social Security Acct is correct. I hereby authorize said assignee to use or disclose all information necessary for treatment, obtaining payment and health care operations.

I certify all the information I have provided to TSAPT is accurate at this time.

I hereby authorize TSAPT to perform any medical treatment as deemed necessary under the New York State Physical Therapy Practice Act.

I have read and agree to the *Office & Financial Policies* above and understand I am responsible for keeping a copy of this information.

_______________________________________ _______________

Signature of Patient («Client Full Name») or Guardian: Date

_______________________________________ _______________

Print Name Front desk initials