CHESAPEAKE
PHYSICAL THERAPY

Please provide the necessary information below as accurately as possible so that we may correctly process insurance billing. Please ask our office staff if there are any questions or concerns. Thank you for choosing Chesapeake Physical Therapy.

Patient Information

Name _____ Date _____/_____/_____ Diagnosis _____

Street _____ Apt. No. _____ City _____ State _____ Zip _____

Telephone (Home) (_____)_____-_____ Work (_____)_____-_____ Cell (____)_____-_____

Date of Birth _____/_____/_____ Social Security No. _____ Sex: M F

Referring Physician _____ Office Phone (_____) _____-_____
Primary Care Physician _____ Office Phone (_____) _____-_____

Are you currently working? (Circle one) Yes No Have you had prior Physical Therapy? (Circle one) Yes No
If you have Medicare, are you currently receiving Home Healthcare Services for any reason? (Circle one) Yes No

Employer Name _____
Address _____ City _____ State _____Zip _____

Insurance Information

Is this injury Workers Compensation or Auto Related? (Circle one) Yes No Specify: _____

Date of Injury _____/_____/_____ Type of Injury_____

Ins Carrier _____ Phone _____ Fax _____

Adjustor _____Claim#: _____

Primary Insurance Information

Ins. Carrier _____ ID# _____ Group# _____

Address _____ Phone (_____) _____-_____

Insured's Name _____ SSN _____-_____-_____ DOB ___/___/____

Secondary Insurance Information

Ins. Carrier _____ ID# _____ Group# _____

Address _____ Phone (_____) _____-_____

Insured's Name _____ SSN _____-_____-_____ DOB ___/___/____

Insurance Benefit Notification

Co-Pay _____ per visit Deductible: _____ Co-insurance _____ per visit
Visits authorized _____ per calendar/contract year

I am aware of the nature and extent of my insurance coverage.

I authorize the release of all medical information necessary to process my medical claims. I also authorize my insurance company to make payment directly to Chesapeake Physical Therapy for services rendered to the above named patient. I understand that I am fully responsible for all charges incurred for treatment rendered to the above named patient.

Signature _____

Date of Initial Evaluation _____/_____/_____ **Time** _____ **PT** _____

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Scheduling, Prescription, Insurance, and Medical Record Policies

We have found that communication with our patients regarding our policies assists us in providing the best service to you. Please take that time to carefully read the sections which pertain to you.

SCHEDULING - We will make every effort to schedule an appointment at the most convenient day and time for you. Remember, it is important that you call at least 24 hours in advance to cancel an appointment so that we may use that time for another patient. If you need to change an appointment, we will make every effort to accommodate your busy schedule. We suggest that you schedule your appointments two or three weeks in advance, whenever possible. This is for your convenience as well as ours. After the third cancellation, you will be referred back to your physician to renew your physical therapy prescription. After two 'no shows', you physician and insurance company will be notified of your failure to keep appointments. This may result in the denial of payment, making you responsible for any outstanding balance on your account.

PRESCRIPTIONS - If required by your insurance carrier, you must first have a valid prescription from a licensed physician for physical therapy. It is the patient's responsibility to ensure the prescription is up-to-date and valid.

****MEDICARE**-** Beginning January 1, 2010 adhering to Medicare guidelines for physical, speech and occupational therapy, there will be financial limitations for therapy services. The dollar amount for the 2010 limitation from January 1, 2010 through December 31, 2010 will be $1,860. You will be responsible for any therapy services provided beyond the Medicare limitation. **Please initial: _____**

INSURANCE - We are happy to bill your insurance company as a courtesy and convenience if we are provided with appropriate billing information. If we do not receive proper information, payment may be required at the time services are rendered.

NO INSURANCE - We are happy to provide services to patients not participating in a health insurance program, but we must insist payment be made at the time services are rendered. We do offer a payment program. Please ask our front office staff for more information.

MEDICAL SUPPLIES - The patient will be responsible for the cost of any durable or medical goods supplied in the event that the insurance carrier does not cover these expenses.

AGREEMENT/AUTHORIZATION

I hereby consent to allow Chesapeake Physical Therapy to provide medical care and to use protected health care information for treatment, payment, and health care operations as stated in the Notice of Privacy Practices. Chesapeake Physical Therapy employees have my permission to contact me by phone, voicemail, answering machine, or mail regarding appointments, collections, or marketing. By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

_____ _____

Signature Date

I acknowledge this facility works with institutions of higher learning, and give my permission to be treated, under close supervision, by a physical therapist or physical therapist assistant students(s).

_____ _____

Signature Date