Centerline Physical Therapy

Patient's Name: _____ D.O.B.: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell #: _____

Business #: _____ Social Security Number: _____

E-mail Address: _____ Height: _____ Weight: _____

Referring Physician? _____ Smoke: Yes, or no

How do you hear about us: Dr. Referral – Friend Referral – Magazine – Other _____

What are the problems you are experiencing: _____
_____
_____

Insurance Information

Name of Insurance_____

ID #_____ Group # _____

Member Services Phone #_____ _____Relationship to Insured_____

Secondary Insurance Information

Name of Insurance_____

ID #_____ ___Group #_____

Assignment and Release

I, the undersigned, certify that I (or my dependent) has insurance as stated above and assign directly to Integrated Physical Therapy all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize CPT to release all information necessary to secure the payment of benefits. I allow fax transmittal of Medical records if necessary. I authorize the use of this signature on all insurance submissions. I authorize the use of this signature to release medical records to primary physician and/or Health Insurance Company.

- I consent to the treatment necessary for the care of the above named patient/client.
- I acknowledge full financial responsibility for services rendered by Integrated Physical Therapy and their staff and understand that the payment of charges incurred is due at the time of the service.
- I have read and fully understand the consent to treat, financial responsibility, and release of medical records information.

Responsible Party's Signature Relationship Date

2146 NE 123rd Street
North Miami, FL 33181
305 967-8976

1000 South Dixie Highway
Hallandale, Fl 33009
954 458-5700

@IPTmiami – IPTmiami.com

Centerline Physical Therapy

Centerline Physical Therapy (CPT) Financial Policy

We are dedicated to providing highly individualized care for our clients. Insurance companies will not dictate the care you receive at CPT. Your plan of care is achieved through the professional assessment of your therapist and is based on your specific functional goals.

In order to maintain our high standard of care and individualized treatment sessions, **CPT does contract with many insurance plans**; however, CPT is an out-of-network provider for all other insurance carriers. We do accept all out-of-network policies **if** your plan has an out-of-network benefit. Please make sure that we have all your current insurance information in order to verify benefits. ***CPT is a participating provider for government supplied Medicare.***

Our guarantee to you:

- Your plan of care will be based on the professional assessment of your physical therapist and physician.
- Insurance companies will not dictate the care you receive.
- Functional goals will be established to meet your specific needs

Billing:

- Payment is expected when services are rendered.
- The patient is responsible for all charges for services provided by CPT.

Cancelled/Missed Appointments:

- Late arrivals are subject to the full fee for the session. We require 24 hours notice for all cancellations. All appointments that are cancelled within less than 24 hours notice or "no-show" are subject to the full fee for the session. With 2 missed appointments, either cancelation or no-show, CPT reserves the right to cancel all remaining appointments.

Courtesy Option:

- If insurance was pre-verified by CPT we will submit your insurance claim.
- Verification is not a guarantee of payment by the insurance company. The patient is responsible for knowing benefit knowledge of his or her own insurance and is responsible for all payment of services.

I have read Centerline Therapy and Wellness's Financial Policy and understand that the client/patient is ultimately responsible for all charges for services provided/rendered by CPT.

_____ _____

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CPT Terms & Conditions

Please read and initial all confirming that you understand and agree to the terms and conditions of our Policy.

____ **Insurance**: In order to maintain our high standard of care, CPT does participate in network with several insurance plans. We do accept all out of network policies depending on if your insurance policy has an out of network benefit. Please make sure that we have all your current information.

____ ***Please be aware that your insurance company may only cover a portion of your service. You, the client/patient will be responsible for the difference.***

____ **Medicare:** CPT is a participating provider for Government Medicare. CPT will bill Medicare directly. The Client/Patient is responsible for any deductible remaining at the time of service, unless, you have a secondary insurance. If not, a $20 co-payment will be collected from you at the time service is rendered. Please be aware, there is a cap/maximum allowable amount on all Medicare allowable claims.

____ **Worker's Compensation:** Worker's Compensation claims will be submitted directly by our office or a billing company directly associated with our office. Please make sure that we have all your current insurance information – including your claim number, date of injury, the name and telephone number of your claims adjuster, and the correct address to where we should mail the claims.

____ **Myofascial Release/Massage/Pilates/Personal Training:** All services under Myofascial Release, Massage, Pilates or Personal Training are paid in full at the time of service. CPT does not bill insurance for these services **unless** these services are rendered as a part of skilled physical therapy.

____ **Automobile Accidents:** CPT will bill your Auto Insurance only under PIP benefits. CPT will not accept assignment on any automobile accident. We do not accept settlement from attorneys or wait for settlement from any automobile carriers.

____ **Durable Medical Equipment (DME) and Supplies**: DMS and Supplies are not reimbursable by insurance companies if sold from CPT and must be paid for at the time you receive such equipment.

____ **Payment** is expected when services are rendered (each visit). We will no longer accept credit cards as payment. For your convenience, we accept Venmo, Zelle, Cash or Checks

____ **Late Charges/Returned Checks:** Any account that remains open beyond 30 days from the last date of service will be subject to a $10.00 fee for each month that the account is not paid in full. There is a $35.00 fee for all returned checks.

____ **CANCELLED/MISSED APPOINTMENTS:** Late arrivals are subject to the full fee for the session. **We require 24 hours notice for all cancellations**. All appointments that are cancelled within less than 24 hours notice or "no-show" are subject to the full fee for the session. With 2 missed appointments, either cancelation or no-show **Fee of $50.00**, CPT reserves the right to cancel all remaining appointments.

____ **Fees:** Initial Evaluations last 53-67 min. Four units plus an eval code will be billed. Subsequent sessions are typically billed at 4 units and is 1 hour. This is subject to change based on what is required on the day of treatment.

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Consent for Treatment:

The patient hereby consents to the administration of appropriate evaluation and therapeutic treatment/procedures as requested by the patient and/or physician prescribing care.

Or

In the case of fitness or treatment provided by a therapist or fitness staff member under the heading of wellness or fitness.

Our Pledge Regarding Medical Information:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at CPT. We need this record to provide you with quality care and to comply with legal requirements. This notice applies to all of the records of your care generated by CPT. We are required by law to:

a. Make sure that medical information that identifies you is kept private.

b. Give you this notice of our legal duties and privacy practices with respect to medical information about you.

Patient Signature_____ Date: _____

If Patient/Client is under 18 years of age, and a parent is not available to attend sessions of Physical Therapy with the minor, the Parent(s) signature for authorization allows CPT to commence Physical Therapy or fitness treatments with the patient who is a minor. The parent(s) is also accepting full financial responsibility for the treatment.

Parent's Signature_____ Date:_____
(If patient/Client is under 18 y/o)

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Patient Profile

We believe in an integrated, holistic, whole-body approach. Therefore, the following information is being requested to aide us in providing you with the most informed care and highest quality of service.

Have you ever had the following?

Yes/No	High blood pressure
Yes/No	Heart disorder
Yes/No	High cholesterol
Yes/No	Lung disorder
Yes/No	Depression
Yes/No	Chronic fatigue
Yes/No	Pacemaker
Yes/No	Allergies to lotions
Yes/No	Diabetes
Yes/No	Anxiety disorder
Yes/No	Incontinence
Yes/No	Stroke
Yes/No	Concussion/TBI
Yes/No	Spinal injury
Yes/No	History of falls

Yes/No	Arthritis
Yes/No	Circulation disorder
Yes/No	Dizzy spell
Yes/No	Seizures
Yes/No	Chronic pain syndrome
Yes/No	Cancer
Yes/No	Osteoporosis
Yes/No	Are you pregnant?
Yes/No	Tobacco use
Yes/No	Gastrointestinal disorder
Yes/No	Headaches
Yes/No	Neurologic disorder
Yes/No	Gynecological disorder
Yes/No	Pain with intercourse
Yes/No	_____

Scar tissue can cause pain and dysfunction in the body. Please list all surgeries you have had, including cosmetic. _____

_____

What, if any, recent diagnostic studies have you had? (MRI, Doppler, X-ray, etc)

_____

History of current condition, including onset date.

_____

_____

_____

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Previous care you have received (physical therapy, chiropractic, acupuncture, injections, etc)

_____
_____
_____

What are your goals for therapy?

_____
_____

At the present time, would you rate your overall general health as:

___excellent ___good ___fair or ___poor

Do you engage in regular physical activity? If yes, please describe.

_____
_____
_____
_____

Is there any thing else you would like us to know?

_____
_____
_____
_____
_____
_____

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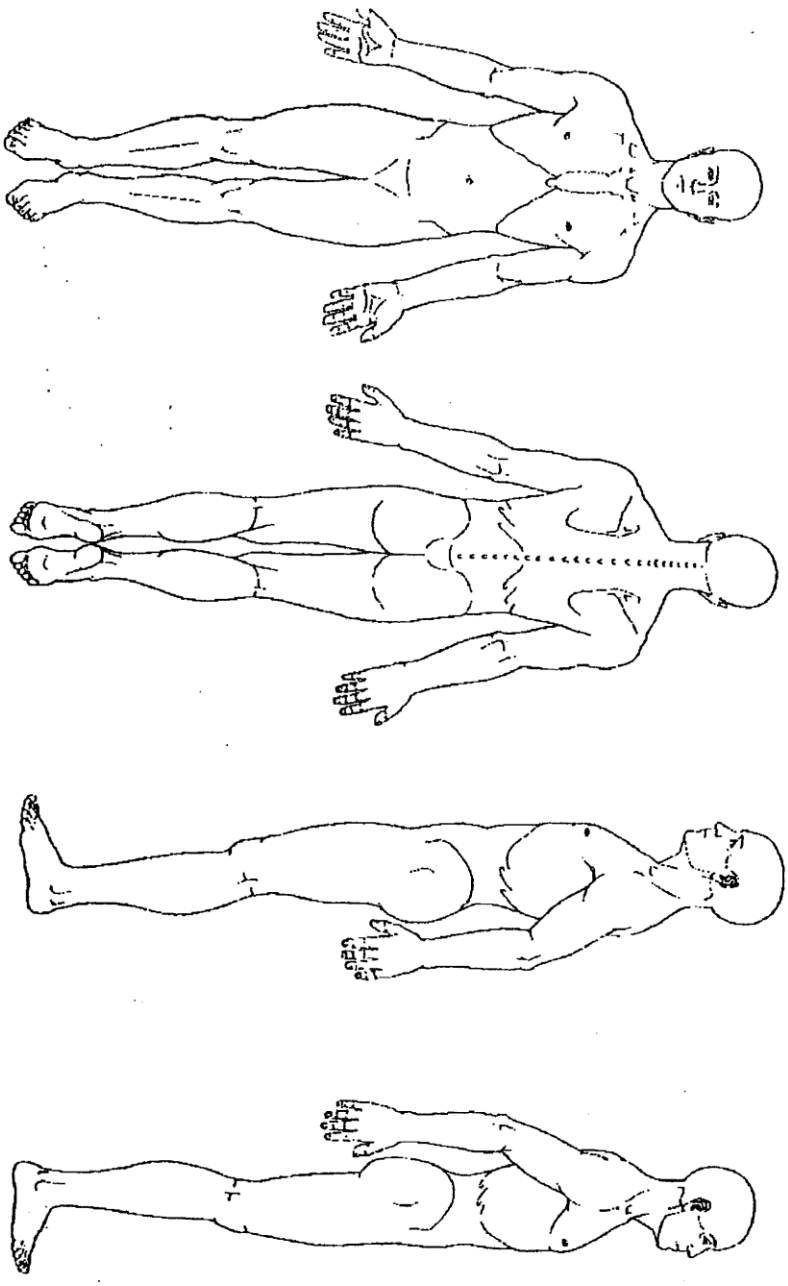
Name: _____ Date: _____

Pain Diagram



PLEASE CIRCLE WHERE YOU ARE HAVING PAIN.

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