CENTERLINE PHYSICAL THERAPY
A Wellness approach to physical therapy

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

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell #: _____

Business #: _____ Social Security Number: _____

E-mail Address: _____

Referring Physician? _____

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

Diagnosis Information

Primary_____ Secondary_____

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 - phone | 305 967-8863 - fax | info@CenterlinePT.com

CENTERLINE PHYSICAL THERAPY
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Centerline Physical Therapy (CPT) Financial Policy

We are dedicated to providing highly individualized care for our clients. Your plan of care is achieved through the professional assessment of your therapist and is based on your specific functional goals.

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.
- 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 that are otherwise not covered by your insurance company. This may include deductible payment, co-pays, co-insurance, or any other monies not covered by your insurance. We highly recommend to you contact your insurance company to know your benefits.**

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 ($50.00)**. 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.

_____ _____

Patient Signature Date

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CPT Terms & Conditions

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

____ **<u>Insurance</u>**: 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.***

____ **<u>Medicare:</u>** 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. <u>Please be aware, there is a cap/maximum allowable amount on all Medicare allowable claims.</u>

____ **<u>Worker's Compensation</u>:** 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 submit the claims.

____ **<u>Myofascial Release/Massage/Pilates/Personal Training</u>:** 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.

____ **<u>Automobile Accidents</u>:** CPT will bill your Auto Insurance only under PIP benefits. CPT may, on a case by case basis, accept assignment on any automobile accident. We may, on a case by case basis, accept settlement from attorneys or wait for settlement from any automobile carriers. CPT maintains the right to select these cases.

____ **<u>Durable Medical Equipment</u> (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.

____ **<u>Payment</u>** is expected when services are rendered (each visit). For your convenience, we Accept checks, cash, Visa, and Master Card and American Express.

____ **<u>Late Charges/Returned Checks</u>:** 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.

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

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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. I am aware that the practice of Physical Therapy is not an exact science, and I acknowledge that no guarantees have been made as to the results of my condition and physical performance status.

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	Gastrointestinal disorder
Yes/No	Headaches
Yes/No	Neurologic disorder
Yes/No	Gynecologic disorder
Yes/No	Pain with intercourse
Yes/No	Tobacco use

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.

_____

_____

_____

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

_____

_____

_____

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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.

_____

_____

_____

_____

LIST OF CURRENT MEDICATIONS:

List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (like Viagra, albuterol, nitroglycerin).

Medication (Brand and Generic Name)	Dose	How and How Often You Take the Medication	Reason for taking	Date Started	Prescriber

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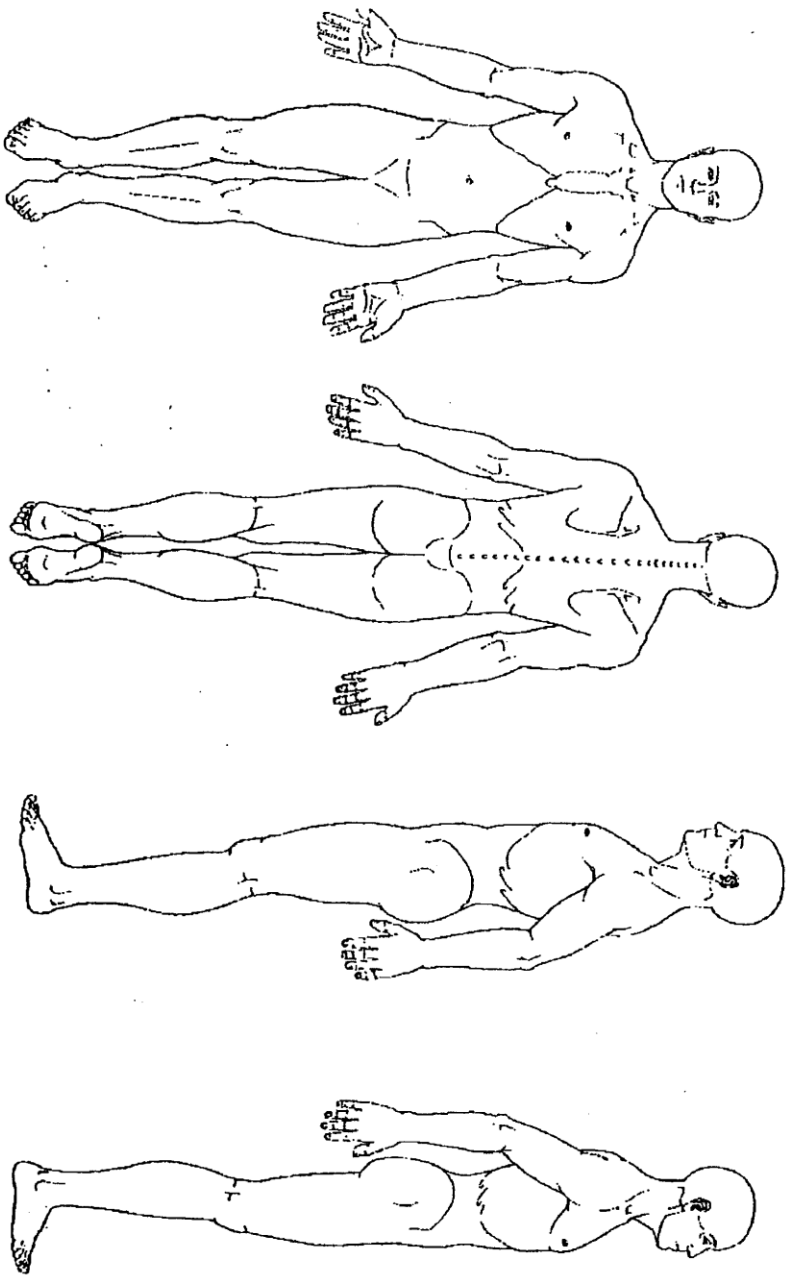
Name: _____ Date: _____

Pain Diagram



PLEASE CIRCLE WHERE YOU ARE HAVING PAIN.

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Advanced Beneficiary Notice of Responsibility

Note:

If Medicare/Medicaid or your Commercial Insurance does not pay for your visit, you will be solely responsible for any services rendered during the visit. This also applies if:

1. There are changes to your plan and your insurance no longer covers physical therapy benefits
2. If you are still deciding/unaware of the plan you are going to have prior to your scheduled visit
3. If you are currently uninsured.

What you need to know:

1. Please read this notice, so you can make an informed decision about your care.
2. Ask us any questions you may have after reading this document
3. All payments must be made at the time of your visit via **Cash, Check, or Credit Card**.

I have carefully read the foregoing Notice of Responsibility, understood its contents and sign it with full knowledge of its significance.

Participant Name_____

Signature: _____ Date: _____

2142 NE 123 ST NORTH MIAMI FL 33180 PHONE: 305-967-8976 FAX: 305-967-8863

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A. AUTHORIZATION TO RELEASE INFORMATION/ASSIGNMENT OF MEDICARE BENEFITS

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 related Medicare claim(s). I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below. Furthermore, I request that payment under the medical insurance program be made to me or to Centerline Physical Therapy. I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize the holder of medical information about me to release it to Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare claim(s). I understand that this is a lifetime signature authorization.

I request that payment of authorized MEDIGAP benefits be made on my behalf to Centerline Physical Therapy, for any services furnished me by (physician/supplier). I authorize any holder of medical information to release to Centerline Physical Therapy, any information needed to determine these benefits or the benefits payable for related services.

B. ASSIGNMENT OF INSURANCE BENEFITS/RELEASE OF INFORMATION

I authorize Centerline Physical Therapy to release to your company or its representative any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such Medical or Surgical care. I also authorize and request your company to pay directly to the above named doctor the amount due me in my pending claim for Medical or Surgical treatment or service by reason of such treatment of service.

C. FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for charges not covered by this authorization and for the guarantees stated above. Also, I understand that it is my responsibility as the insurance to pay all copayments and coinsurance at the time of the visit.

D. APPOINTMENT POLICY

I understand that I will be charged a fee for appointments not canceled within 24 hours. This includes canceled appointments, rescheduled appointments, and missed appointments ("no-shows"). Appointments may be canceled via telephone. The fee is $50.00 but is subject to change at the discretion of Centerline Physical Therapy.

Please initial here _____

E. REFERRALS AND AUTHORIZATIONS

I understand that it is my responsibility to obtain all authorizations or referrals necessary for treatment. If an authorization or referral is not obtained by the time of the visit, the visit will be rescheduled and considered a same-day cancellation, resulting in a fee. (SEE ABOVE)

I, THE PATIENT OR GUARANTOR, CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE TO THE BEST OF MY KNOWLEDGE. I ACCEPT RESPONSIBILITY FOR THE MEDICAL CHARGES INCURRED BY THE PATIENT AND AGREE TO PAY ALL BILLS AT THE TIME OF SERVICE UNLESS OTHER ARRANGEMENTS ARE MADE. I AUTHORIZE PHYSICIAN AND PRACTICE TO RELEASE ANY INFORMATION TO PROCESS INSURANCE CLAIMS. I ALSO AUTHORIZE MY INSURANCE CLAIMS TO BE PAID DIRECTLY TO THE PRACTICE OR ITS REPRESENTATIVE.

Signature:_____ Printed Name:_____

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INTEGRATED PHYSICAL THERAPY & WELLNESS

Where Health and Wellness Meet Mind and Body

The purpose of this reservation form is to allow us to serve you in the best way possible. When you schedule an appointment at IPT, the time is reserved for you. Since we are reserving this spot just for you, please be conscious of your time and the therapists time.

Important Details:

- Cancellations made with less than 24-hour notice will result in a full charge
- No show patients will result in a full charge

If any changes occur, letting us know on time allows other clients to have the blissful opportunity for healing.

I _____ hereby authorize Integrated Physical Therapy to charge my credit card account in the full amount of my scheduled session in the event that I do not call to cancel or reschedule my appointment at least 24 hours in advance of my scheduled appointment or with prior notice.

CREDIT CARD INFORMATION

Credit Card # _____

Expiration Date _____ 3-digit CVV/AVS code _____

BILLING ADDRESS

Street _____

City _____ State_____ Zip Code_____

As the credit card holder, I hereby authorize this transaction.

APPOINTMENT REMINDER

We will remind you of your next appointment 24 hours prior to your scheduled appointment. Please indicate your preference:

Phone call to _____

Email to _____