WELCOME TO Fitness Forum

Financial 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.

PRESCRIPTIONS - Most insurance companies require a valid prescription from a New York Licensed Physician, Dentist, Podiatrist or Nurse Practitioner for physical therapy reimbursement. It is the patient's responsibility to ensure the prescription is up-to-date and valid.

****MEDICARE****- Adhering to Medicare guidelines for physical, speech and occupational therapy, there are financial limitations for therapy services. **The dollar amount for the 2016 limitation from January 1, 2016 through December 31, 2016 is $1,960.** 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. As a courtesy we will verify your insurance benefits for physical therapy. ***However, we strongly advise you to contact your insurance company directly to obtain this information since it is ultimately the patient's responsibility to know and understand their insurance benefits.***
Please initial: __________

COPAYS, COINSURANCE, DEDUCTIBLES - It is our policy to collect co-pays at the time of service. Co-insurance is an estimated amount and we may not know the exact amount until the claims are processed. Therefore the estimate is based on the *average* patient responsibility. If there is a balance due after your insurance processes we will bill you for the difference between the amount you have paid and what the insurance states is the patient responsibility amount. If you have a deductible which has not been met you may be asked for payment on this as well.
Please initial: __________

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.

AGREEMENT/AUTHORIZATION

"I hereby assign, transfer and convey payment and authorize said payment to be made directly to Fitness Forum Physical Therapy, PC for any medical benefits, sick benefits, injury benefits due because of liability of a third party, or proceeds of all claims resulting from liability of a third party, payable by any party, organization, etcetera, to or for discharge or completion of all outstanding obligations related to this medical treatment. I further agree that this assignment will not be *withdrawn or voided* at any time until this account is paid in full. I understand that I am responsible for any charges not covered by my insurance company and for deductible and copays. I realize that the provider may be required to release medical information on my behalf for the purpose of obtaining payment, to settle a dispute to facilitate payment and other reasons outlined in our Privacy Policy. Fitness Forum Physical Therapy, PC has the right to charge reasonable collection fees and add these fees to my account balance if I fail to pay outstanding charges on my account. The undersigned individually obligates him/her to pay the account of the provider in accordance with the regular rates and terms of the provider:

______________________________ ______________________________

Signature **Date**

Fitness Forum Physical Therapy
Patient Information/Health History

Patient Name ______________________________ Date ______________

Date of onset, injury, or surgery ______________ What was your initial treatment? ______________

Have you had other treatment for this condition? Yes ________ No ________ If yes, please explain ____________

Are you taking any medication now? Yes __________ No__________ If yes please list all medications: **MEDICATIONS LIST**
If you need to, please continue your medications list on the back.

Do you now, or have you ever had, any of the following:

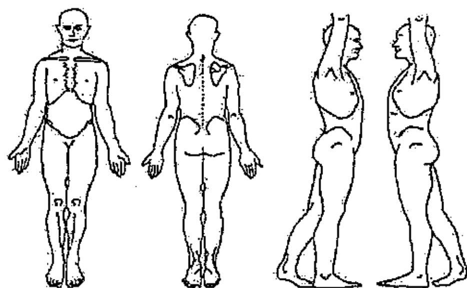
Diabetes	_______	High Blood Pressure	_______
Heart Disease	_______	Stroke/CVA	_______
Pacemaker	_______	Migraine Headaches	_______
Kidney Problems	_______	Rectal Bleeding	_______
Allergies (list below)	_______	Bowel/Bladder Irregularity	_______
Hernia (Ventral, Inguinal, etc.)	_______	Seizures	_______
Metal Implants	_______	Dizziness	_______
Cancer	_______	Pregnant (currently)	_______
Abdominal Pain	_______	Menstrual Irregularity	_______
Muscle Disease / Disorder	_______	Nerve Disease / Disorder	_______

Previous Surgeries (list year & type): ______________________________

Any other medical conditions the Physical Therapist should be aware of: ______________________________

If yes to any of the above, please explain on back and give approximate dates.

Pain Chart & Questionnaire



Please mark the body charts above in the areas where you experience pain related to today's therapy visit.

Briefly Describe your pain(circle all that apply):

constant intermittent sharp dull achy burning

Pain Scale: Please Circle level of pain

Current: 0 1 2 3 4 5 6 7 8 9 10
No pain moderate pain worst pain possible

At its best: 0 1 2 3 4 5 6 7 8 9 10
No pain moderate pain worst pain possible

At its worst: 0 1 2 3 4 5 6 7 8 9 10
No pain moderate pain worst pain possible

Any futher description / explanation of pain: ______________________________

I certify to the best of my knowledge, the above information is correct.

I understand I will be provided with a description of my individualized physical therapy treatment plan to be rendered. It will include the potential benefits and any associated risks of physical therapy. I understand that my attendance, in accordance with the prescribed treatment plan, is critical to maximizing the potential benefits of my physical therapy treatment plan. I have read and understand the information above, and agree to consent to physical therapy treatment to be provided by Fitness Forum personnel.

Signature ______________________________ Date ______________

☐ Patient ☐ Legal guardian ☐ Power of attorney

Fitness Forum

HIPAA Contact Information

May we leave a message regarding your **appointment**: (Please circle answer)

Home Phone (include Auto Call)	Yes	No
Mobile Phone (include Auto Call)	Yes	No
Mobile Text (include Auto Call)	Yes	No
Work Phone	Yes	No
With Another Person	Yes	No
Send via Mail	Yes	No
Send via Email	Yes	No

May we leave a message discussing **medical information**: (Please circle answer)

Home Phone	Yes	No
Mobile Phone	Yes	No
Mobile Text	Yes	No
Work Phone	Yes	No
With Another Person	Yes	No
Send via Mail	Yes	No
Send via Email	Yes	No

EMAIL ADDRESS: ____

Please List person(s) authorized to discuss medical information:

Name: ______________________________ Relationship: _______________

Name: ______________________________ Relationship: _______________

Name: ______________________________ Relationship: _______________

Emergency Contact: ____________________________________ Phone #:_______________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been offered or have received the Notice of Privacy Practices from Fitness Forum.

Signature____ **Date**____________________________

Fitness Forum
Physical Therapy

Missed Appointment Policy

Fitness Forum Physical Therapy and our staff take your health very seriously. Your physician has recommended physical therapy to improve your daily life. We are sure that you will receive the best therapy at Fitness Forum. We appreciate your confidence.

Physical Therapy improves your function and daily life through a variety of treatments that have been proven successful. **Your physician and physical therapist have agreed on the frequency of your treatments. It is important that you attend your therapy appointments consistently to gain maximum benefit from your visits. Frequent cancellations are very detrimental to the outcome of your treatment.**

We make every effort to schedule appointments in a way that maximizes your time spent with the therapist. If you are late, it creates a disruption for not just you, also the therapist and all of the other patients.

We understand that occasionally there may be a need to reschedule an appointment. **If you need to reschedule an appointment we require a 24 hours notice. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferably the very next day. Should you cancel or no show for your appointment more than one time during a 12 visit course of treatment, there will be a charge of $20.00 for each cancellation or no show.** If you no show for an appointment more than three times you will be discharged from therapy. Obviously, we do understand emergencies arise.

(Note: If you are a worker's compensation patient, your insurance company will not reimburse for cancelled and missed appointments. You will personally be held responsible for these fees).

Please understand this policy is intended to improve the quality of care that you receive from our clinics. We guarantee that a therapist will be here every time you come in so that you receive outstanding care.

We thank you for understanding and we look forward to your great health.

I have read and understand the Cancellation / No Show policy as described above and agree to make every effort to maintain my therapy schedule to maximize the benefits of physical therapy.

Patient Signature ______________________ Date ______ Staff Initials ______