Annapolis Family PHYSICAL THERAPY

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Authorization and Financial Policy

Thank you for choosing Annapolis Family Physical Therapy (AFPT) as your health care provider. We are committed to providing you with the best possible care. We would like to take this opportunity to review our billing and payment procedures with you. Please understand that payment of your bill is considered a part of your treatment. We would like to assist you in receiving your maximum allowable benefits from your insurance. In order to achieve these goals, we need your assistance and understanding of our payment policy. You are required to present a valid insurance card and photo identification on your initial visit. Copayments, co-insurance and self-pay payments are due at the time of service. We accept cash, personal checks, Visa, MasterCard, Discover and American Express. To effectively bill your insurance company, we need complete and accurate insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. It is your responsibility to contact your insurance company regarding payment or questions regarding your medical insurance coverage.

Commercial Insurance Carriers

1. You agree to be responsible for all of our charges, even if you have insurance. If you have any questions as to our fees for your care, please let us know before continuing your treatment.
2. You understand that AFPT will not accept the responsibility for collecting your insurance claim, or negotiating a settlement for you, if a dispute arises between you and your insurance company. If such a dispute should arise, you agree to pay your outstanding balance to AFPT and then pursue the reimbursement for your insurance company thereafter.
3. We bill most insurance carriers for you if proper paperwork is provided to us. If your insurance has not paid within 60 days of billing, fees are due in full from you.
4. We do not submit claims to secondary insurance, unless you have Medicare as your primary insurance.

Medicare

1. Our office is a Medicare participating provider and we will bill Medicare for you. Medicare will automatically crossover the majority of claims to your secondary insurance company, if applicable. If your secondary claims do not crossover, it is the responsibility of the patient to file these claims.
2. There are some services that are not covered by Medicare benefits and Medicare will not pay for them. When you receive an item or service that is not covered by Medicare you will be asked to sign an "Advance Beneficiary Notice of Non-coverage" (ABN) form. You will be responsible for any services not covered by Medicare.
3. You understand that AFPT will not accept the responsibility for collecting your secondary or supplemental insurance claims, or negotiating a settlement for you.

Workers Comp/Auto Claims

1. If your visit is work or auto related we will need the claim number, carrier, and adjuster's information prior to your visits in order to obtain authorization and bill the appropriate insurance company.
2. If you benefits are exhausted, you are responsible for any services received. You may provide us with your health insurance information in an attempt to obtain payment for your services. You will be responsible for providing AFPT with a copy of your exhaustion letter to be attached to your claims when they are billed to you health insurance.
3. We do not do Third Party Billing.

INITIALS _____

All Patients

1. If your patient account balance becomes over 30 days past due, and you have not made satisfactory arrangements with our billing office, you agree to pay an administrative service charge of 1 ½ % per month on the unpaid balance.
2. We do not bill insurance for medical supplies. We ask for payment for any medical supply used as part of your treatment on the day they are issued.
3. We do not bill insurance for massage therapy. You will be responsible for payment in full on the day of your massage.
4. If you find that you are unable to keep an appointment, please notify us at least 24 hours in advance. We reserve the right to bill you if you fail to keep a pre-scheduled appointment, or if you cancel with less than 24 hours notice. Our customary fee of $35.00 will be billed to your account for a broken pre-scheduled appointment. Since insurance companies and workers compensation do not pay for broken appointments, you agree that these charges are solely your responsibility.
5. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.

Consent for Care and Treatment

I understand that I have been referred for physical therapy care and treatment to Annapolis Family Physical Therapy, Inc. I understand that I have the right to ask and have any questions answered regarding the treatment plan that has been prescribed for me. By signing this agreement, I consent to have Annapolis Family Physical Therapy, Inc. provide care and treatment as prescribed by my physician and/or recommended to my physical therapist.

Insurance Assignment

I authorize an irrevocable assignment of benefits and payment directly to Annapolis Family Physical Therapy, Inc. for my or my child's treatment and authorize the release of medical information necessary to process my claims. I further understand that I am financially responsible for charges not covered by my insurance company. In the event payment is received by me from my insurance company, I will remit payment promptly to Annapolis Family Physical Therapy, Inc. Interest chares of 1 ½ % will accrue monthly for balances greater than thirty days outstanding from initial patient statement.

Legal Assignment

I agree that if, upon default, this matter is referred to an attorney or agency for collection, the responsible party agrees to pay any fees that may be charged to AFPT by the collection attorney or agency. As well as any and all court costs incurred therewith.

Disclosure of Information

There may be times when it is necessary for an individual directly involved in your care to call Annapolis Family Physical Therapy to inquire about your personal health information or billing information. I authorize AFPT to disclose my health information that is directly related to my current treatment at AFPT to the Individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If you are the representative of the patient, circle the scope of your authority to act on the patient's behalf:

Parent / Guardian / Power of Attorney / Other: _____

I have read and understand the contents within Annapolis Family Physical Therapy's Authorization and Financial Policy.

_____ _____

Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, Annapolis Family Physical Therapy creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among Annapolis Family Physical Therapy personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill. I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for Annapolis Family Physical Therapy that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that Annapolis Family Physical Therapy may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that Annapolis Family Physical Therapy is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Annapolis Family Physical Therapy, Inc. and agree to the liability limitations explained therein.

_____	_____	_____
Signature of patient or legal representative	Date	Relationship to Patient

_____

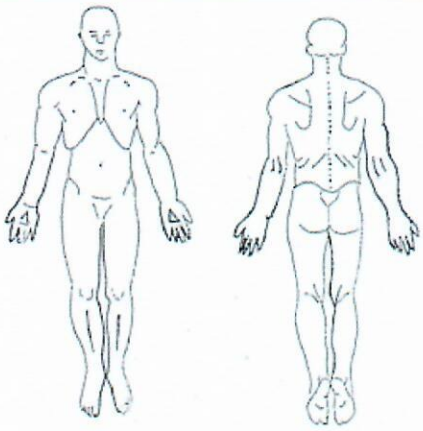
Printed name of patient
Effective date April 14, 2003
Revised date September 23, 2013

Annapolis Family PHYSICAL THERAPY

Medical History Form

Under Medicare and the Maryland practice act we are required to obtain a complete medical history on all patients. This information is protected under HIPAA laws. Please answer all questions to the best of your ability.

Last Name: _____ First Name: _____ MI:_____ Date: ____/____/____
DOB: ____/____/____ Age: _____ Sex: M / F Height: _____ Weight: _____
Referring Doctor: _____
If accident, circle place where occurred: Home / Auto - State _____ /Work / Sports / Other
Occupation: _____ Current work status: _____
What is your chief complaint? _____
Briefly describe how your problem began: _____
What goals would you like to achieve through therapy?_____
Date of onset/injury: ____/____/____ Date of surgery:____/____/____ Type of Surgery: _____
Have any diagnostic tests have been performed for this problem? (circle all that apply)
X-rays/ Bone Scan/ Doppler/ Ultrasound/ MRI/ EMG/ CT Scan/ Bloodwork/ Other: _____
Please list body part tested and date tested: _____
Have you had similar symptoms in the past? Y / N Have you received PT prior to coming here? Y / N



Describe pain: sharp cramping aching throbbing dull
burning shooting stabbing squeezing sore
constant / intermittent other: _____
What makes it worse? _____
What makes it better? _____
Does time of day affect pain? _____
Does pain wake you from sleep? _____

Please rate your pain on 0-10 scale
(0 is no pain, 10 is the worst you can imagine): 0 1 2 3 4 5 6 7 8 9 10

Do you have any of the following:

Diabetes	Chest Pain/Angina	Surgeries	Arthritis	Ringing in your ears
Pacemaker	Headaches	Heart Disease/High B.P.	Heart Attack	Heart Palpitations
Scoliosis	Rheumatoid Arthritis	Kidney Problems	Cancer	Nausea/Vomiting
Smoking	Metal Implants	Are you Pregnant	Any Allergies	Asthma/Breathing Problems
Seizures	Fractures	Dizziness/Fainting	Hernia	Liver/Gall Bladder Problems

Other: _____

Do you have any tingling, numbness or loss of skin sensation? Y / N If so, where ? _____
What increases this? _____ What decreases this? _____
Do you have any weakness? Y / N , where? _____ How long has it been present? _____
Do you have any swelling? Y / N , where? _____ How is it being managed?_____
Have you had any recent falls? Y / N Do you use any of the following: Cane/ Walker/ Crutches/ Wheelchair
How would you rate your current health? _____

List all previous surgeries and dates: _____
_____
List all medications/supplements you are taking: _____
_____

List all allergies that you may have: _____

To the best of my ability, I have given and included all pertinent medical information.

Patient/guardian signature: _____ Date: ____/____/____