



## Email Collection Form

Dear Twin Boro Patient,

You are an essential part of our existence for the past 38 years. As we continue to grow and serve your community, we would greatly appreciate your input on your experience at Twin Boro. As a valued patient we want to know where we can improve to make your experience with us all the more enjoyable and successful. Please help us to achieve these goals by providing your email below. Use of your email will be limited to the following two items.

- Quarterly newsletter: with health education and injury prevention tips.
- Twin Boro Connect text messaging service

***Email addresses will only be used by Twin Boro Physical Therapy and will not be sold or made available for use by any other organizations.***

Please Print

Name: \_\_\_\_\_

Email: \_\_\_\_\_



## Consent to Treat/Release of Information

### CONSENT TO EVALUATE AND TREAT

I do hereby consent to the evaluation and treatment by TwinBoro Physical Therapy Associates. I understand that it is my right to accept or refuse any treatment offered to me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

### RELEASE OF INFORMATION

I authorize Twin Boro Physical Therapy to release information from my medical record, whether it be written, video, photographic, audio or verbal, to my physician and/or any third-party payor or other entity providing payment for my health care (such as insurance company, employer, or governmental agency) for its use in processing claims for payment. I understand the nature of the authorization and have been informed that I have the right to revoke consent at any time by written communication with custodians of records. I consent to the release of medical information to \_\_\_\_\_ for communication and care coordination on my behalf.

### ASSIGNMENT OF BENEFITS

I request that payment of Medicare and/or other insurance benefits be made on my behalf to TwinBoro Physical Therapy Associates for any services furnished by TwinBoro Physical Therapy.

### FINANCIAL AGREEMENT

The undersigned agrees, whether signing as agent or patient, that she/he individually obligates her/himself to pay for services rendered in accordance with the regular rates and terms of TwinBoro Physical Therapy Associates. TwinBoro will verify insurance benefits on behalf of the patient as a courtesy. However, verification is **not a guarantee** of payment and patients can call their insurance companies as well to confirm this information. The agent/patient is responsible for any co-payment, deductible, coinsurance and all amounts identified by the insurer as the patient's responsibility.

### INSURANCE COVERAGE

I understand that if I fail to disclose any effective insurance coverage at the time of this signing or after the first service date when said insurance became effective, I will be held responsible for any balances not covered by said insurance. This includes balances due to lack of authorization.

- I do not have secondary coverage.
- I choose not to use my secondary coverage.

The undersigned certifies that s/he has read, understood and accepts the terms of this form, received a copy, and is the patient or is duly authorized by the patient as the patient's general agent to execute this form.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Account Number



Dear Patient,

Welcome to our practice. Thank you for your confidence and trust in scheduling an appointment with our clinic. We are always dedicated to quality care for all our patients and we are always here to discuss your problems and find together the most appropriate solution. Our office patient policies are as follows. Please read carefully the following policies and sign below.

### GENERAL OFFICE POLICIES

- 1) We require 24 hours notice in the event of a cancellation. It is your responsibility when you call in ***to have an alternative time in mind that will ensure you receive your full prescribed number of treatments that week whenever possible.***
- 2) There is a **\$25.00** charge for a no show or cancellation without proper notice. This charge will not be covered by your insurance company, and will have to be paid by you personally.
- 3) You should understand that when you no-show, three people get hurt: 1) yourself, because you are not receiving the treatment you need as prescribed by the doctor and our staff, 2) the therapist, who now has a "vacancy" in their schedule since the time was personally reserved for you, and 3) another patient, who could have been scheduled for treatment if you had given us proper notice.
- 4) **Regarding Lateness:** If you are late, we may not be able to provide your full treatment.
- 5) **Regarding Being Early:** We will do our best to get you in as soon as possible. Most of the time you'll have to wait until your scheduled time to be seen because there are other patients who are still in treatment.
- 6) Please understand that your insurance policy is a contract between you and your insurance company. While we may accept your insurance as payment, your contract with us is a separate agreement. In other words, if your insurance refuses to cover a certain treatment or otherwise fails to pay us, your contract with us still exists and you are responsible for payment personally.
- 7) **Co-pays, deductibles, and self-pay payments** are due at the time of service. We accept Mastercard, Visa, cash, check or money order **only**.
- 8) We will assist with a budgeted payment plan based on individual need. In any event, if you request such a plan, this will be set up directly with our practice billing department.
- 9) If at any point you have a problem regarding billing and payment please speak with the Office Coordinator of the clinic.

***After you have read carefully the above, please sign the following:***

I, \_\_\_\_\_, agree to be treated in this Physical Therapy clinic by the Physical Therapist and their staff and I also agree with the terms specified above.

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Patient Name (print)**



NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ DOB: \_\_\_\_\_

Weight: \_\_\_\_\_ Weight: 5 yrs ago \_\_\_\_\_ Height: \_\_\_\_\_ Height: 5 yrs. Ago \_\_\_\_\_

DOCTORS: Referring: \_\_\_\_\_ Family: \_\_\_\_\_ Others: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_

**Why do you have pain?**

Fall  Car Accident  Work  Sports  Unknown  Other \_\_\_\_\_

**Briefly describe how you were injured and your present complaints?** \_\_\_\_\_

*Please check if you have any of the following:*

**Cardiovascular:**

Cardiac Disease I70.8  
 Pacemaker Z95.0  
 Hypertension I11.9  
 Congestive Heart Failure I27.9  
 Stroke G46.4  
 Peripheral Vascular Disease I73.9

**Respiratory:**

Asthma J45.20  
 COPD J44.9  
 Bronchitis J41.0  
 Emphysema J43.8

**Nervous System:**

Seizures G40.89  
 Neuropathies G60.8  
 Parkinson's Disease G20  
 Multiple Sclerosis G35  
 Epilepsy G40.901  
 Polio G14

**GI Conditions:**

Crohn's Disease K50.919  
 Irritable Bowel Syn K58

**Other:**

Allergy- LATEX Z91.040  
 Anemia D50.9  
 Cancer/Malignant C80.1  
 Diabetes Type 1 E10.9  
 Diabetes Type 2 E11.8  
 Kidney Disease E11.8  
 Liver Disease K76.9  
 Fibromyalgia M79.9  
 Mental Illness F09  
 Alzheimer's Dis G30.9  
 Migraine G43.9  
 Headache G44.2  
 Balance Issues R29.6  
 Lupus M32.9  
 Overweight E66.3  
 Anorexia F50.0  
 Visual Loss H54.7  
 Hearing Loss H91.9  
 Gout M10.0  
 Scleroderma M34.9  
 Osteoarthritis M19.90  
 Osteoporosis M81.0  
 Osteopenia M85.8  
 High Cholesterol E78.2

