Email Collection Form

Dear Twin Boro Patient,

You are an essential part of our existence for the past 30 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.

- Patient Satisfaction Survey: will be emailed to you asking a series of questions evaluating our services, our site, and our demeanor.
- Quarterly newsletter: with health education and injury prevention tips.

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 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 TwinBoro 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 s/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. Verification is **no guarantee** of payment. 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.**

MEDICARE/ HOME HEALTHCARE

As a Medicare beneficiary, I am aware that I can not receive physical therapy through an independent clinic if I am currently enrolled with a Home Healthcare Agency. If services were provided and I was not formally discharged by the agency, I realize that I will be held responsible for services denied by Medicare.

_____ I have received some form of home healthcare. _____ I have not received some form of home healthcare.

Patient Initials Patient Initials

MEDICARE PRIMARY HORIZON BLUE CROSS BLUE SHIELD SECONDARY

Although Medicare will cover an evaluation and/or re-evaluation procedure, Horizon BCBS may or may not pay for these procedures. Should Horizon deny, the patient will be held responsible for the Medicare coinsurance on these and any other services Horizon deems patient responsibility.

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 allow, on special occasions, a long-term payment plan budgeted on the individual according to need. In any event, if you request such a plan, you will sign a written agreement which will be sent and approved by corporate.
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's Name (print)

PHYSICAL THERAPY
Twin Boro

Medicare Secondary Payor Questionnaire

Patient Name: _____ Clinic Name: _____
Medicare ID #: _____ Patient Account #: _____
Date: _____

1 Are you entitled to Medicare Based on Age (65 and over) YES NO
Disability YES NO
End Stage Renal Disease YES NO

2 Do you receive Veteran's Benefits? YES NO

3 Are you receiving benefits under the Black Lung Program? YES NO

4 Was this injury due to a work-related accident or condition? YES NO
If YES, indicate accident date: _____

5 Was this injury due to a motor vehicle accident? YES NO
If YES, indicate accident date: _____

6 Was this injury related to an accident in which you intend to file a liability suit or litigation is pending?
YES NO
If YES, indicate accident date: _____

If YES, please provide attorney name: _____
Attorney address: _____
Attorney Phone: _____

7 Are you currently employed? YES NO
If NO, indicate date of retirement: _____

8 Are you currently receiving primary health coverage from current or previous employer?
YES NO

9 Is your spouse currently employed? YES NO

Do you have coverage under a group plan through spouse's employer?
YES NO

If YES, does the employer have more than 20 employees? YES NO

PHYSICAL THERAPY
Twin Boro

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 ___ Spor ____ Unknown Other _____

Briefly describe how you were injured and your present complaints? _____

_____

_____

Please check if you have any of the following:

Cardiovascular:	**ICD-10**
____ Cardiac Disease	I70.8
____ Pacemaker	Z95.0
____ Hypertension	I11.9
____ Congestive Heart Failure	I27.9
____ Stroke	G46.4
____ Peripheral Vascular Disea	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:	**ICD-10**
____ 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 Problems	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

PHYSICAL THERAPY
Twin Boro

PAST SURGERIES: *TYPE* *DATE*

[1] _____ _____
[2] _____ _____
[3] _____ _____
[4] _____ _____
[5] _____ _____

MEDICATIONS: Dosage Frequency

[1] _____ _____
[2] _____ _____
[3] _____ _____
[4] _____ _____
[5] _____ _____
[6] _____ _____
[7] _____ _____
[8] _____ _____
[9] _____ _____
[10] _____ _____

Are you, or do you think you may be pregnant? Yes ____ No ____

Do you have any METAL IMPLANTS? Yes____ No_____ Where_____

Motor Vehicle Accidents: Yes / No Dates: _____

Have you broken any bones? Yes / No Where? _____

Do you smoke? Yes / No How many years? _____

Do you have children? Yes / No Ages: _____

What sports or recreational activities do you participate in? _____

_____

Occupation: _____ Full Time/ Part Time/ Retired/ Student/ Not Employed