PHYSICAL REHABILITATION NETWORK

Patient Information & Financial Policies (PPO)

Benefits & Payment Policy:

As a courtesy to you, PRN will bill your insurance company. We will call your insurance to verify that you are eligible to receive benefits and check on pre-authorization policies to determine whether we have a contract with your insurance plan.

Please be aware a prescription from your Referring Doctor is not an "authorization" and does not guarantee your insurance carrier will cover the entire cost of all services. All billed charges are based on medical necessity. *You are responsible to know your own healthcare benefits.* We strongly advise patient's to contact their insurance carrier regarding Outpatient Physical Therapy benefits and coverage. Any change of insurance while receiving services from PRN, may affect your coverage and/or authorization. You are responsible to inform the front staff of any insurance changes before services are rendered. Failure to provide change of insurance information (including a change of PCP and/or medical Groups) may result in a denial of claims for unauthorized visits. You will be financially responsible for non-covered charges denied by your Health Insurance Carrier. You will be financially responsible for the allowable amounts under patient liability approved by your Health Insurance Carrier. Dual health coverage does not always guarantee both insurances will cover the entire cost of you rehabilitation services. ***All copays and deductible amounts are due at the time of service. The deductible is the initial dollar amount due from the member before your health insurance company begins paying for the services.***

The information listed below is a description of your healthcare benefits provided to us by a Representative from your Health Insurance Carrier. It is not a guarantee or authorization of payment. *Actual benefits cannot be determined until the claim has been received and finalized by your Health Insurance Carrier.*

Benefits Verified By: _____ Date: _____ ☐ Benefits Verified On-Line (See Attachment)

Insurance Plan: _____ Provider Svc #: _____ Time of Call: _____Circle: AM/PM

Rep Name: _____ Call Reference#: _____

Patient: _____ Policy Holder Name: _____DOB: _____

Insurance Card(s) must be scanned into the NextGen Chart.

1. Does this Policy have a HSA attached: ☐NO ☐YES If yes, Amount: $_____Remaining: $_____
2. Deductible: ☐NO ☐YES
   If yes Amount: $_____ Applied: $_____ Remaining: $_____
3. Out of Pocket Maximum: $_____ Amount Applied: $_____ Remaining: $_____
4. Outpatient Therapy Max Dollar Amount: ☐NO ☐YES If yes Amount: $_____Remaining: $_____
5. Outpatient Therapy Plan Coverage: _____% Patient Coinsurance_____% *Patient may pay an estimated amount towards their coinsurance balance if a contracted daily rate does not apply. Patients will be billed the remaining financial responsibility balances approved by the Health Insurance Carrier.
6. Copayment: ☐NO ☐YES ***Amount Due Per Visit: $***_____
7. Number Visits Allowed: _____ ☐Calendar Year ☐Based on Medical Necessity
   a. Combined: ☐NO ☐YES → *Circle Services Combined* – PT OT ST Chiro

Combined Visits Used: ☐NO ☐YES → *# Amount Used:* _____ ***Note: Patient is responsible to inform the clinic of any prior Rehabilitation Therapy Services received from another Provider/Facility Clinic during the current year. Any visits beyond the allowable calendar amount will not rendered unless patient agrees to be financially responsible. *Cash Pay Form must be presented and signed and dated to the Patient.***

8. Does this policy require Pre-Authorization/Notification for Outpatient Therapy?

☐NO ☐YES If yes – Authorization Dept. Number: _____

Authorization Dept Fax#: _____

☐Send the following documentation for Review: Rx_____ Initial Eval_____

☐Fill out Insurance Carrier Authorization Form provided online.

☐Additional Comments: _____

**Check All that Apply:*

☐ Pre-Auth is required beyond 24th visit or visit maximum (less than 24) for all PPO insurances.

☐ Guardian requires pre-auth after the 5th visit.

☐ BC SISC requires Notification/BS PCIP.

☐ Plan covers therapy for 2 months from Initial Evaluation.

☐ Cigna/American Specialty Health(ASH) _____Requires Auth after 5 visit _____Group Plan does not apply

☐ Sutter Select _____Requires Auth after 8th visit _____Requires Auth from PAMF after 10th visit (Interplan)

☐ Rx required for billing/payment.

9. Does the Policy cover Hand Therapy rendered by a Occupational Therapist? ☐NO ☐YES ☐N/A

10. Does the Policy cover SPLINTS & DME? ☐NO ☐N/A

☐NO ☐YES →*Auth*→☐*YES* → Deductible: $_____ Coverage/Coinsurance: _____

11. Medical/Professional Claims Billing Address:

have read and understand the policy above. I understand the financial arrangements and medical insurance policies, and agree to comply. I m aware of my responsibility to pay for my copayment at the time of service.

atient Signature: _____ Date: _____

MEDICAL HISTORY

ALL INFORMATION IS PRIVATE AND CONFIDENTIAL. PLEASE PRINT

NAME OF PERSONAL PHYSICIAN:_____

OFFICE TELEPHONE:_____

List any prescribed medications you are now taking:

DRUG	DOSE	FREQUENCY
_____	_____	_____
_____	_____	_____
_____	_____	_____

DO YOU HAVE OR HAVE YOU EVER HAD?

____High blood pressure
____Chest pain or discomfort
____Rapid heart beat or palpitations
____Extra or skipped heartbeats
____Dizziness or lightheadedness
Shortness of breath:
____a) with minimal exertion
____b)while sitting
____c)while lying down
____d)with night awakening
____Multiple joint pain
____Kidney Disease
____Cirrhosis or other liver disease
____Cancer
____Diabetes
____Ulcer or intestinal bleeding
____Hypoglycemia (low blood sugar)
____Skin rash or bruises
____Migraine or recurrent headaches
____Faintness upon standing
____Epilepsy
____Persistent cough
____Increased anxiety or depression
____Problems with recurrent fatigue
____Trouble sleeping
____Pain in legs after walking
____Swollen feet or ankles
____Hep A,B,C, HIV, AIDS
____Rheumatoid Arthritis
____Polio
____Infectious Mononucleosis
____Asthma/Emphysema
____Night sweats
____Infectious diseases
____Other medical conditions

I understand that SPORTFIT PHYSICAL THERAPY leases space from CLUBSPORT. I also understand that during the course of treatment I will be using facilities and equipment owned by SPORTFIT and facilities owned by CLUBSPORT, and do so at my own risk. I assume full liability for any injuries or damages which may occur to self in, on, or about the premises of said facilities, and do hereby fully forever release and discharge the said facilities, their owners, shareholders, employees, agents and related entities from any action or cause of any action present or future resulting from or arising out of the use of said facilities or their equipment.

_____ _____

PATIENT SIGNATURE or PARENT SIGNATURE DATE

PATIENT PRIVACY NOTICE

SPORTFIT PHYSICAL THERAPY

THIS ABBREVIATED NOTICE BRIEFLY DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to personnel who are involved in taking care of you.

For Payment: We may use and disclose health information about you so that the services you receive from us may be billed to insurance carriers and payment collected.

For Health Care Operations: We may use and disclose health information about you for operations that are necessary to run our practice.

Health-Related Services and Treatment Alternatives: We may use and disclose health information to tell you about health-related services.

Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Veterans: If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs.

Workers' Compensation: We may release health information about you for workers compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Health Oversight Activities: We may disclose health information to a health oversight agency as authorized by law.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order etc..

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care.

Right to Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information.

Right to an Accounting of Disclosures: You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations.

Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location.

Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of the entire PHI Privacy notice at any time.

We reserve the right to change this notice at any time. We will post a copy of the current notice in our facility.

If you would like a complete copy of the Protected Health Information Privacy Notice, please ask the Patient Account Representative.

_____ _____

Patient Signature **Date**

SportFit Bollinger Physical Therapy

Consent and Statement of Financial Responsibility

1. **CONSENT FOR TREATMENT:** I consent to and authorize my physical therapist, occupational therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment.

2. **APPOINTMENT ATTENDANCE AGREEMENT:** I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times give one week do not automatically follow through to subsequent weeks. I agree to provide at least 24 hours notice when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel/no show charge of $30 or $60 depending on appointment type.

   WORKER'S COMPENSATION PATIENTS: We appreciate your full cooperation in attending all scheduled therapy sessions. We are required to inform your Worker's Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments. It is also required that all missed visits be rescheduled.

3. **RESPONSIBILITY FOR PAYMENT:** All co-payments are due at the time of service. I acknowledge that in consideration of the services provided to me by SportFit Physical Therapy, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide SportFit Physical Therapy with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible.

   Please note that refusal to sign this form does not change responsibility for payment in any way.

4. **ASSIGNMENT OF BENEFITS:** I hereby assign to SportFit Physical Therapy all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

5. **CONSENT FOR EMERGENCY CONTACT INFORMATION**

   Person to contact in case of an emergency:

   _____ _____ _____
   Name Telephone Number Relationship:

6. **MEDICARE PATIENTS**: Have you received any prior physical therapy this year? (circle) YES NO Have you received any home healthcare services this year? (circle) YES NO

   By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

   _____ _____
   Signature of Patient or Legally Responsible Person Date

   _____ _____
   Printed Name of above Date