Focal Point Physical Therapy

FEEL. BETTER.

25 Plaza Drive, Unit 6 Scarborough, Maine 04074 P: 207-289-1010 F: 207-289-1011 www.focalpointpt.com

PATIENT INFORMATION

FIRST NAME _____ **MI** ___ **LAST NAME** _____

GENDER M/F_____ **DOB** _____ **(Preferred Name)** _____

HOME ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

E-MAIL _____

PHONE(please check preferred)**:**Cell( )_____ Home**( )** _____Work( )_____

PRIMARY CARE DR. _____**REFERRING DR.** _____

DIAGNOSIS / AREA OF CONCERN: _____

Are you currently receiving Home Health services (Nursing, PT, OT, speech)? Y / N

If you have received therapy in another facility for PT or OT this year, the number of visits you received: _____

RELEASE OF MEDICAL RECORDS. FPPT and its employees may, in accordance with the Privacy Policies, provide to any of my insurance carriers information necessary to process claims for services rendered to me by FPPT provider(s). By signing below, I AUTHORIZE EMPLOYEES OF FPPT TO SHARE MEDICAL INFORMATION, as needed, with: my physicians and healthcare providers providing treatment to me. **Initials** ____

** I also authorize (circle) *appointment times* and *medical information* to be **shared with the following individual(s):**

_____

EFFECTS OF PHYSICAL THERAPY/ COMMUNICATION WITH STAFF.

I understand that physical therapy can be demanding on my body and that there are sometimes side effects from physical therapy sessions. Upon signing this waiver, I HEREBY AKNOWLEDGE THAT I AM AWARE there are possible EFFECTS, AND UNDERSTAND THAT Focal Point STAFF WILL UTILIZE PHYSICAL THERAPY TECHNIQUES FOR MY BENEFIT DURING THE COURSE OF MY TREATMENT(s). IT IS MY RESPONSIBILITY TO COMMUNICATE COMFORT AND MEDICAL CHANGES to physical therapy staff. I understand that therapists at FPPT are licensed as Physical Therapists or Physical Therapy Assistants in the state of Maine, and will perform all work necessary under approved state license guidelines.

I FURTHER AGREE to communicate changes to diagnoses, medical status, address, name, and insurance coverage changes in a timely manner. **Initials** _____.

Signature of Patient _____ **Date** _____

Privacy

NOTICE OF PRIVACY PRACTICES has been provided for me to read. I UNDERSTAND MY PRIVACY RIGHTS. I understand that staff at FPPT will uphold the practices of HIPPA as outlined. A copy will be provided for me at my request**. Initials** _____.

BILLING INFORMATION

INFORMATION REGARDING MY INSURANCE CARRIER'S COVERAGE. FPPT provides this information for my benefit, but I am aware **it is my responsibility as the patient to be aware of actual coverage, co-payments, co-insurance, deductible information, etc. I am aware that if for any reason these services are not covered by insurance (s) listed above, I AM FULLY LIABLE FOR ANY UNPAID SERVICES.** If I require a copy, one has been provided for me. **Initials** _____

Auto Liability Claims, Worker's Compensation claims, and Personal injury claims: : we require a claim number, a billing address, and contact person with contact phone number. **Initials** _____

UNPAID SERVICES. I realize that if for ANY reason these services are not covered by insurance (s) listed above, I am fully liable for any unpaid services. I acknowledge this by signing below. I also acknowledge that it is my responsibility to assist FPPT by providing correct information in a timely manner. Lastly, I agree to consult w/ office and billing staff about changes in my coverage or personal information. **Initials** _____

RETURN CHECK POLICY. There will be a $25.00 service charge for each check returned by the bank for insufficient funds. **I have read and understand this policy. Initials _____.**

Same Day Cash Rate: If you are no longer covered by insurance, or prefer to pay out of pocket, we offer massage, personal training, and physical therapy treatments (or a combination of any of these). We offer 30, and 60 minute sessions. We also offer events and classes. Please ask our front office staff for details and prices.

Payment information can be discussed with the following individuals:_____

Payment Policy: I AUTHORIZE PAYMENT OF BENEFITS TO BE RELEASED DIRECTLY TO Focal Point manual therapies (FPMT), DBA Focal Point Physical Therapy, as the PROVIDER. **Initials** ___

Billing: We do our billing in-house, and the billing program is integrated with our treatment note program to reduce errors. You will receive statements from us once your insurance company communicates coverage of your service date (s) with us. Please call 289-1010 with questions. Our billing staff works evenings and weekends, but office staff will field questions and direct your inquiries in a timely manner. If you ever have questions regarding billing, do not hesitate to ask. We are happy to work with you if you need to create a payment plan, and we have over 15 years of experience working with insurance coverage. We update ourselves continuously, so if you have new information for us we are very willing and capable to hear you.
You may pay bills, co-payments, and co-insurance by phone, in person, or through our patient portal.

Signature of Patient _____ **Date** _____