Frederick
Physical
Therapy, Inc.

Tel: (301)631-5300
Fax: (301)631-5301

196 Thomas Johnson Drive,
Suite 225,
Frederick, MD 21702

Name: _____

Physical Condition: Excellent ____ Good ____ Fair ____ Poor ____

Dominant Hand: _____ Height: ____'____" Weight _____ lbs.

Diagnosis/Condition: _____

Previous treatment for this condition? _____

Refer to Diagram A.

Please **mark on the diagram** directly to your right your chief compliant. Refer to **KEY** below to help clarify your symptoms. Use the text area below for additional notes:

_____

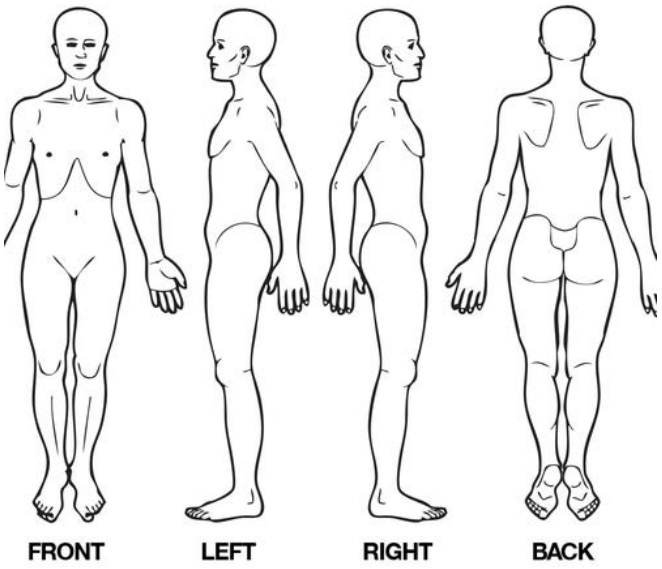
_____

**** KEY ****

+	-----	dull ache
~	-----	tingling
0	-----	numbness
X	-----	burning
=	-----	pain
#	-----	other

_____

_____



(Diagram A)

INFORMATION RELEASE

I, _____, authorize Frederick Physical Therapy, Inc. to furnish information from the patient record to:

1. **My Insurance Company and Policy Holder**
2. **_____**
3. **_____**
4. **_____**

_____ _____

Signature Date

EMERGENCY CONTACT

Name: _____ **Tel:** _____

Relation: _____

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Today's Date _____ Primary Care Physician _____ Referring Doctor _____

Last Name _____ First Name _____ MI _____ Suffix _____

Is this your legal name? _____ If not, what is your legal name? _____

Email: _____ Former Name _____

Date of Birth _____ Age _____ Marital Status _____

Home Address (Street Address, City, State, Zipcode) _____

Occupation _____ Employer _____ Employer Telephone # _____

Social Security Number*: _____

How did you hear about FPT? _____

Do you have any friends or family who were/are patients at FPT? _____

Indicate (X) if you have any of the following Allergies _____
Anxiety _____
Breathing Problems _____
Cancer _____
Dental Problems _____
Depression _____
Diabetes _____
Dizziness _____
Headaches _____ (freq? _____, duration? _____, how many per week? _____)
Heart/Circulation Disease _____
High Blood Pressure _____
HIV _____
Pacemaker _____
Pregnant Now _____
Recent Weight Loss _____
Rheumatoid Arthritis _____
Seizures _____
Seizures _____
Steroid Use _____
Surgeries _____

Please list current medication(s) below, including what they're treatment for:

_____
_____
_____
_____
_____
_____

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---------- INSURANCE INFORMATION ----------

Primary Insurance

Insurance Company: _____
Member ID: _____ Group #: _____

Effective Date: _____
Policy Holders Name and DOB: _____
Policy Holder's Social Security #: _____

MAKE SURE TO HAVE YOUR PAYMENT READY IF YOU HAVE A COPAY OR DEDUCTIBLE!

Secondary Insurance

Insurance Company: _____
Member ID: _____ Group #: _____

Effective Date: _____
Policy Holders Name and DOB: _____
Policy Holder's Social Security #: _____

Third Insurance

Insurance Company: _____
Member ID: _____ Group #: _____
Effective Date: _____
Policy Holders Name and DOB: _____
Policy Holder's Social Security #: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the Physician. I understand that I am financially responsible for any balance. I also authorize Frederick Physical Therapy, Inc. or insurance company to release any information required to process my claims.

Patients Signature: _____ Date: _____

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ACKNOWLEDGE OF RECEIPT, NOTICE OF PRIVACY PRACTICE.

You may refuse to sign.

I, _____, have received a copy of this offices' Notice of Privacy Practices.

_____ _____

Patient Signature Date

ASSIGNMENT AND RELEASE

I, _____, have insurance coverage with_____ (name of insurance company), and assign directly to Frederick Physical Therapy, Inc. all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize FPT to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____

Signature of Insurer/Guardian **Date**

MEDICARE AUTHORIZATION

I, _____, request that payment of authorized Medicare benefits be made either to me or on the behalf of Frederick Physical Therapy, Inc., for any service(s) furnished to me by Frederick Physical Therapy, Inc. I authorize any holder of Medicare information about me, to release to, Health Care Financing Administration and its agents. Any information needed to determine these benefits or the benefits payable for related services, I understand my signature requests that payment be made and authorizes release or medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCA-1500 form, elsewhere on other approved claim or forms or electronically submitted claims, my signature authorizes the release of information to the insurer or charges determination of the Medicare assigned cases. Frederick Physical Therapy, Inc. agrees to accept the charges determination of the Medicare as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Coinsurance and the deductible are based upon the share determination of the Medicare carrier.

_____ _____

Beneficiary Signature **Date**

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Name _____ **Date** _____

PAYMENT POLICY

UPDATED JULY 15, 2019

UCR (Usual & Customary Rates): Our practice is committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area. Frederick Physical Therapy, Inc. (FPT) has contracts with most insurance companies, where these rates are non-negotiable. You are responsible for payment in full, regardless of any insurance companies arbitrary determination of usual & customary rates.

Patients are responsible for payment **at the time of each visit** for all services rendered to them by FPT, including HMO/PPO/IPA/POS coverage, thus the appropriate copayment/deductible is due at the time of service. Any returned checks will be charged at $35.00 per check payable in cash. **If you do not make your copayment/deductible at the time of service, a $5.00 bill charge will result.**

If you are unable to keep a scheduled appointment, please notify FPT Staff 24 HOURS IN ADVANCE (1 billing day prior based upon your appointment time); failure to do so will result in a fee. I understand that my first missed (no show, same day cancels, not giving 24 hour notice, etc..) will be waived- no questions asked. If a second appointment is missed without 24 hour cancellation, a $70.00 fee will be applied to patient's balance, and a bill will be issued. Additional appointments (3+) not canceled with a 24 hour notice, FPT has the right to cancel all future appointments, resulting in discharge from our office. My signature indicates that I will be responsible for these charges, and I understand that my insurance company is not reliable for these charges.

Frederick Physical Therapy, Inc. will bill date of service physical therapy visits to the patient's primary insurance carrier as a courtesy to the patient. Payments received to FPT by the insurance carrier will be applied to any outstanding balances. If payment from insurance company is not made within 90 days of our billing date, the balance for the bill amount becomes due and payable by the patient. When the patient is a minor, the parent/legal guardian assumes all financial responsibility.

Frederick Physical Therapy, Inc. does not accept patients on a contingency basis. In automobile injury cases, the patients PIP insurance will be billed directly. When a patient is examined or treated for a condition that may be a result of an accident of injury, if litigation is involved, or the injury is covered under Worker's Compensation (WC),, it is ultimately the obligation of the patient to pay all outstanding balances in full, and will not in anyway become contingent upon the outcome of any claim or injury.

I understand and accept that it is MY obligation to pay for any and all physical therapy charges for which I am billed for by FPT. I understanding I am responsible for also paying any and all fees associated with collection of my outstanding balance, including but not limited to any reasonable attorney fees, should legal counsel or collection agency become necessary. I further understand that if my outstanding balance become more than 30 days past due, I will be responsible for paying interest at 2.5% per month on balance due, until it is paid in full. Consult with Billing Department at FPT if payment plan needs discussed.

I hereby acknowledge that I have read this contract in its entirety, and have had all of my questions answered. I fully understand this contract and agree to its terms.

Patient Signature: _____

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