Body Balance and Beyond

Physical Rehabilitation and Wellness Center

New Patient? Yes ☐ No ☐ Today's Date: _____

Are you currently receiving Physical Therapy at another location? Yes ☐ No ☐

Are you currently receiving Home Health Care? Yes ☐ No ☐

Patient Information

Last Name:_____First Name _____ Middle Initial_____

Address: _____

City/ State/ Zip:_____Email: _____

Phone number to call and leave messages:

( )_____( )_____( ) _____

Home Work Mobile

Date Of Birth :_____Age:_____Sex: Male ☐ Female ☐

Marital Status: Single: ☐ Married:☐ Other:☐

Date of Injury/ Onset Date:_____Diagnosis: _____

Medicare: Yes ☐ No ☐ If yes, have you exceeded your Medicare Cap? Yes ☐ No ☐ Amt Used-$_____

Auto Related: Yes ☐ No ☐ If yes, Adjustor Name:_____

Phone #: ( )_____

Claim #: _____

Work Related: Yes ☐ No ☐

Primary Insurance Information

Name of Insurance Company:_____Policy#: _____

Patient relationship to Policy Holder: Self ☐ Spouse ☐ Dependent ☐ Other_____

If policy holder is Not Self, please provide information about the policy holder:

Last Name:_____First Name_____Middle Initial____

Address:_____

City/ State/ Zip:_____Email:_____

Phone: ( )_____ ( )_____( )_____

Home Work Mobile

Date Of Birth :_____Age:_____Sex: Male ☐ Female ☐ SSN#_____-____-_____

Secondary Insurance Information

Name of Insurance Company:_____Policy#: _____

Physician Information

Name of Physician:_____Phone#: ( ) _____

Emergency Contact Information

Contact Name:_____Home Phone#: ( )_____Cell#: ( )_____

Relationship to Patient: Parent ☐ Spouse ☐ Sibling ☐ Other _____

CONSENT

Consent for Treatment. I hereby give my consent to receive treatment by a rehabilitation provider. I have listed all health insurance plans from which I may receive benefits. I request that payment of authorized insurance benefits for services be assigned to Body Balance and Beyond Inc. I herby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by my insurance, if Body Balance and Beyond Inc. does not participate with my insurance. I agree to pay all co-payments, coinsurance, and deductibles at the time services are rendered.

I,_____, herby authorize Body Balance and Beyond Inc. to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment, and health care operation.

Our Payment Policy. The patient is responsible to check with their insurance carrier for exact coverage. As a courtesy to our patient, we take the time to obtain information from your insurance company in regards your coverage including co-insurance and co-payment for your physical therapy sessions. Your insurance dose not guarantee any of the information they provide us, therefore, the information we provide you cannot be guaranteed. The insurance carrier makes final determination, based upon the plan's level of coverage and associated policies upon receiving the claim. **The PATIENT is ultimately responsible for the TOTAL BILL regardless of the insurance coverage**.

I acknowledge and agree that if I cancel my physical therapy session less than 24 hour prior to my appointment, or if don't show up for my appointments**, I will be responsible for a $75.00 fee for each late canceled appointment and each non-attended appointment.** It is my responsibility for a Return Check Fee of $30 for each returned check. I am also responsible for a $25 Chargeback-Retrieval Fee for each chargeback fee that occurs through the use of my credit card.

Medicare patient: I understand that Medicare will cover only 80% of allowable amount for my outpatient physical therapy visits. I will be responsible for the remaining 20%.

I understand that while this consent is voluntary, if I refuse to sign this consent, Body Balance and Beyond Inc. can refuse to treat me.

I have been informed that Body Balance and Beyond Inc. has prepared a notice ("Provider Notice") that more fully describes the uses and disclosures that can be made of my individuality identifiable health information for treatment payment and health care operations. I understand that I have the right to review such Notice prior to signing this consent. I understand that I may revoke this consent at any time by notifying Body Balance and Beyond Inc., in writing, but if I revoke my consent, such revocation will not affect any actions that Body Balance and Beyond Inc. took before receiving my revocation. I understand that Body Balance and Beyond Inc. has the right to change its ("Provider Notice") and that I may obtain such changed Notice by contacting the office to request a copy.

Herby I confirm that I have received the "Notice of Privacy Practices" via e-mail to the e-mail address listed above ☐ or as paper copy ☐ .

I have read and agree with all the above terms and policies.

Signature of Patient or Patient's Representative Date

Direct Physical Therapy Treatment Services

You are receiving direct physical therapy treatment services from an individual who is a physical therapist licensed by the Physical Therapy Board of California.

Under California law, you may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing you with physical therapy treatment services only after receiving, from a person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California, or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice, a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care and that an in-person patient examination and evaluation was conducted by the physician and surgeon or podiatrist.

Patient's Signature: Date:

PATIENT CONSENT FORM AND EXPLANATION OF FINANCIAL TERMS

Welcome to Body Balance and Beyond. Your insurance carrier may require that treatment be rendered only upon referral by a physician. This referral should be provided to us at your initial visit (evaluation).

● **APPOINTMENT INFORMATION:** Please arrive 5 to 10 minutes early for your visits. If you are more than 30 minutes late, your therapist's schedule may prevent you from being seen. In that case, your session is considered a No-Show and a late fee of 75.00 will apply. In the event that you are unable to attend your appointment, we require at least 24 hours advance notice. There is a $75.00 missed visit fee for failure to comply.

● **BILLING INFORMATION:** Insurance Coverage: Please verify your insurance coverage with us at the time of your initial visit. Body Balance and Beyond is a participating provider with Medicare and with most PPO plans. For your convenience, we will attempt to contact your insurance company to verify your benefits at our clinic prior to your initial visit. However, there is no guarantee of payment from your insurance company. **Please direct any inquiries about your coverage to your insurance company.** For your convenience, we will submit your claim forms to your insurance carrier for you. **Co-payment, coinsurance, and any deductible owed are expected at each time of service.**

● Copay/Coinsurance and Deductible Collection: After submitting your physical therapy claim to your insurance company, it can take up to 4 weeks for your insurance company to response with an "Explanation of Benefit" (EOB). The EOB will inform us with more details of your Copay/Coinsurance and Deductible responsibilities. Based on your coverage benefits and eligibilities, we will collect an estimated fee of $75-$150 for each physical therapy visits **if you have <u>not met</u> your deductibles**. We will collect an estimated $15 Copay/Coinsurance for each physical therapy visits **if you have <u>met</u> your deductibles.** Once we receive the EOB, we will recalculate your responsibility. We will refund you any overpayments or create an invoice if a balance is due.

● **AGREEMENT FOR PAYMENT OF SERVICES:** By signing this Agreement, you are accepting responsibility for payment of treatment rendered. If payment is not made and additional collection efforts are required, you agree to pay all bills rendered for treatment together with all collection costs, interest fees, and reasonable attorney's fees of 35% of the balance due. All bills are payable and become due upon presentation. Your unpaid balances of fees are subject to Finance Charges at an annual percentage rate of eighteen percent (18%) per annum, which corresponds to a monthly periodic rate of 1.5%.

● **Medicare Patients**: Medicare regulations prohibit us from billing you directly for your physical therapy visits. We will notify you in advance if Medicare does not cover your physical therapy sessions.

● **ACKNOWLEDGEMENT:**
I have read and understood all of the above information contained in this Agreement, and agree to abide by all of its terms. I further acknowledge that I am either the patient or have been duly authorized by the patient as the patient's general agent to execute the above and accept its terms.
I consent to the procedures which may be performed at my physical therapy evaluation and during the duration of this treatment.
I understand that it is ultimately my responsibility to pay Body Balance and Beyond for all services provided and to assure that my insurance carrier properly processes my claims.

_____ _____
Signature Date

AUTHORIZATION FOR DIRECT PAYMENT AND RELEASE OF RECORDS:
I hereby authorize Body Balance and Beyond to apply for benefits on my behalf for services rendered by them. I request payments from my insurance carrier be made directly to Body Balance and Beyond. I also authorize Body Balance and Beyond, at its option, to pursue on my behalf any appeals of the denial of my insurance benefits, and to release my medical records as required to determine benefits payable. I authorize Body Balance and Beyond to furnish medical records information in its possession relative to my diagnosis, treatment, and account status to other treating physicians, healthcare providers, and my insurance carrier(s) and their agents.

_____ _____
Signature Date

<u>PERMISSION TO TREAT A MINOR</u>

I _____, the parent of _____, who is a minor, hereby give permission for Body Balance and Beyond to treat my child in my absence. It is policy that no child under the age of 14 is allowed to be dropped off or treated in the absence of their parent.

_____ _____
Parent/Legal Guardian Date