Fitness In Therapy

2164 Route 35, Bldg C
Sea Girt, NJ 08750
P: (732)974-1313 • F: (732) 974-9661

NAME_____E-MAIL_____
PRINT LAST FIRST

ADDRESS_____

CITY_____ STATE _____ZIP _____ DRIVER'S LIC. # _____

S.S. #_____ AGE _____ DATE OF BIRTH _____MARITAL STATUS _____

HOME TELEPHONE _____ WORK TELEPHONE _____

CELL PHONE NUMBER:_____

PATIENT'S EMPLOYER _____
(IF MINOR, THEN PARENT)

ADDRESS _____

OCCUPATION _____ ARE YOU WORKING NOW? □ **YES** □ **NO** ***(CIRCLE ONE)*** FULL TIME PART TIME

SPOUSE'S NAME _____

OCCUPATION _____

EMPLOYER'S ADDRESS _____

INSURANCE INFORMATION: **PRIMARY** **SECONDARY**

INS. CO. NAME _____ INS. CO. NAME _____

INS. CO. ADDRESS _____ INS. CO. ADDRESS _____

_____ _____

INS. CO. TELEPHONE _____ INS. CO. TELEPHONE _____

NAME OF POLICY HOLDER _____DOB_____ NAME OF POLICY HOLDER _____DOB_____

POLICY HOLDER S.S.#_____ POLICY HOLDER S.S.#_____

POLICY # _____ GROUP # _____ POLICY # _____ GROUP # _____

CLAIM # _____ CLAIM # _____

IS THIS A COMPENSATION CASE? □ **YES** □ **NO** DATE OF ACCIDENT _____/_____/_____

IS THIS A LIABILITY CASE? □ **YES** □ **NO** □ **MVA** □ **NEGLIGENCE** DATE OF ACCIDENT _____/_____/_____

IN YOUR OWN WORDS PLEASE EXPLAIN HOW INJURY OCCURRED: _____

_____

IF APPLICABLE ATTORNEY'S NAME _____

ATTORNEY'S ADDRESS _____

FINANCIAL AGREEMENT & AUTHORIZATION FOR TREATMENT.
I authorize treatment of the person named above & agree to pay all fees & charges for such treatment. I agree to pay all charges to me shown by statements promptly upon presentation thereof unless credit arrangements are agreed upon in writing. It is agreed the payments will not be delayed or withheld because of any insurance coverage or pendency of claims, thereon & all proceeds of insurance are assigned to this office where applicable but without their assuming responsibility for the collection thereof. I also authorize Fitness In Therapy to release such information as required by the above insurance carrier.

PATIENT'S SIGNATURE _____ DATE_____
(IF MINOR, THEN PARENT)

1. ARE YOU CURRENTLY TAKING ANY MEDICATION? PLEASE LIST MEDICATION AND REASON FOR USE.

2 . HAVE YOU EVER HAD?

	YES	NO		YES	NO
HEART ATTACK			KIDNEY DISEASE		
ANGINA PECTORALIS			EPILEPSY		
EKG ABNORMALITIES			ANEMIA		
EMPHYSEMA			ASTHMA		
CHRONIC BRONCHITIS			NECK OR BACK DISORDER		
LOW BLOOD PRESSURE			FRACTURES		
HIGH BLOOD PRESSURE			WHERE:		

HAVE YOU EVER HAD?

	YES	NO		YES	NO
PULMONARY SURGERY			STROKE		
DIABETES			THYROID TROUBLE		
SCARLET FEVER			DISEASE OF ARTERIES		
RHEUMATIC FEVER			LOW BLOOD SUGAR		
BONE OR JOINT DISEASE			GLAUCOMA		
CANCER			ARE YOU CURRENTLY PREGNANT?		

3. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY ILLNES? YES_____ NO_____
IF YES, PLEASE GIVE DETAILS:

4. PLEASE LIST ANY OTHER PHYSICAL DISORDERS YOU HAVE OR HAD WHICH SHOULD BE CONSIDERED REGARDING YOUR PHYSICAL THERAPY AND EXERCISE PROGRAM (I.E. PREGNANT, ETC.)

FAMILY PHYSICIAN _____Telephone#_____

ADDRESS _____ CITY_____ STATE_____ ZIP _____

WOULD YOU LIKE YOUR FAMILY PHYSICIAN TO RECEIVE A COPY OF YOUR PHYSICAL THERAPY REPORT? YES_____ NO_____

PATIENT'S INITIALS (IF MINOR, THEN PARENT)

Fitness In Therapy (Please Initial on the appropriate line acknowledging you have read that section)

As a courtesy to our patients, **Fitness In Therapy** (FIT PT) offers the service of billing insurance companies directly.

_____Physical Therapy sessions consists of an initial evaluation ($100.00), and the use of multiple modalities each costing between $20.00 and $6 5.00 per unit. I.E. Ultra Sound, TENS, Whirlpool, Paraffin, Traction, Electrical Muscle Stimulation, Therapeutic Exercises, etc. There could be additional fees, for example: isokinetic evaluations, re-evaluations, work conditioning, ADL, pool therapy, various accessories (lumbar rolls, cervical pillows, home exercise devices, etc.) and narrative reports. Each therapy session lasts approximately one to two hours.

_____Private Insurance: Most insurance companies pay between 70% and 80% of the total charges for physical therapy, providing the deductible is met. If you are in a Network, it is your responsibility to make sure you have chosen the proper facility and all the proper forms have been received. If we are in your Network it does not relieve you of the responsibility of making sure we are paid! Fitness In Therapy will pursue the patient's insurance company for payment, up to three months. If payment is not received within 90 days, a payment schedule will then be arranged directly with the patient. Fitness In Therapy will continue to assist the patient in their attempts to gain reimbursement from their insurance carrier. **The residual balance is the responsibility of the patient.** By law FIT may add 18% annually to any outstanding bills. **All co-payments are due at the time of each visit.**

_____Workers Compensation: If you were injured at work and have reported it, and a claim has been set up, you will be covered 100%. Please remember it is ***YOUR RESPONSIBILITY***, to provide all necessary information to file your claim accurately. Should your claim be denied due to physician advisory review, you will be held responsible.

_____Medicare: We are **MEDICARE APPROVED**. We bill Medicare on a daily basis. Medicare will pay 80% of all eligible charges up to with the exception of yearly deductibles. Patients are responsible for the 20% co-payment plus any deductible that has been applied to our charges. Medicare requires FIT, as a provider, to monitor utilization of claims based on your diagnosis. You will be informed when continued therapy is not deemed covered under your Medicare insurance. Please discuss this process with our office should you have any questions. By signing below you "certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration of its related Medicare claim. I request that payment of authorized benefits be made on my behalf." By signing below you also authorize FIT, through its appropriate personnel, to perform or have performed upon me, on the below named patient, appropriate assessment and treatment procedures. We will submit to your secondary insurance which will cover approximately 80 to 100% of the 20%. *Any remaining balance becomes your responsibility. The Medicare cap for Physical Therapy is $2,040. If you have had any Physical Therapy services at any time this year please notify the front desk assistant. If not bills accrued after you have met the cap will become your responsibility.*

_____Motor Vehicle and Liability Cases: If you were in a **motor vehicle accident or involved in a liability case** and you have an attorney: you hereby authorize payment directly to Fitness In Therapy such sums due and owing him for services rendered both by reason of this accident and by reason of any other bills that are due FIT and to withhold such sums from any settlement, judgment or verdict as may be necessary to adequately protect and fully compensate Fitness In Therapy. And, I hereby further give a lien on my case to Fitness In Therapy against any and all proceeds of my settlement, judgment or verdict which may be paid to you, my attorney or myself as the result of the injuries for which I have been treated or injuries in connection therewith. Patient acknowledges that any private insurance payment made on account of services provided by FIT does not constitute payment in full, if such payments are less than amounts billed.
Please acknowledge this by signing below that you have been advised that if your attorney does not wish to cooperate in protecting the therapist's interest, Fitness In Therapy will not await payment but may declare the entire balance due and payable. If we do obtain a Letter of Protection you automatically waive the statute of limitations.

***We highly recommend that patient's contact their insurance companies to verify their coverage. Payment is the* ultimate responsibility of the patient**. If we have to pursue payment of your outstanding bill with the use of a lawyer we will be adding the above interest plus an additional 25% for legal fees.
In the event a patient submits a payment for less than the full outstanding balance and indicates that said payment shall be "Payment In Full" please be advised that FIT shall apply the payment to the outstanding balance and same shall not be considered in accord and satisfaction of the outstanding bill.
In the event of a returned check, there will be a $25 bank fee charged to the patient.
FIT reserves the right to terminate treatment if 2 appointments are canceled or not attended without 48 hours notice.

Patient Signature _____ Date _____

Guardian Signature _____ Social Security # _____
Are you currently serving in any branch of the military? ____YES ___NO, If yes which branch:_____

Fitness In Therapy

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____

I, _____, have received **Fitness In Therapy**'s Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by **Fitness In Therapy**, my individual rights, how I may exercise these rights, and **Fitness In Therapy**'s legal duties with respect to my information.
I understand that **Fitness In Therapy** reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, **Fitness In Therapy**. I understand I can obtain **Fitness In Therapy**'s current Notice of Privacy Practices on request.

Signature:_____ Date:_____
Relationship to patient (if signed by a representative of patient):_____

Assignment of Benefits

In consideration of services rendered to me, _____
I hereby authorize payment to the above named physician any and all insurance benefits to which I may otherwise be entitled for services rendered by the provider but not to exceed the provider's regular charges for such services.

In the event the provider's charges are outstanding, I hereby assign to the provider all benefits to which I may be entitled and authorize the provider to file such a claim and/or action on my behalf so the provider may receive payment for their charges. I understand that, if the provider does not receive payment from the insurer, I remain personally responsible for the payment of the provider's charges.

This authorization or photocopy hereof, will further authorize you to furnish any and all information you may have regarding my condition while under your observation or treatment, including history obtained, diagnostic findings, physical findings, diagnosis and prognosis. You are authorized to provide this information in accordance with the applicable law.

This assignment authorization is irrevocable and will remain valid until the provider is paid in full for services rendered.

Date:_____ Patient Signature:_____
Date of Accident: _____(where applicable)