

WELCOME TO McCARTHY PHYSICAL THERAPY

Insurance: Your insurance is a contract between you and your insurance carrier. We will gladly bill you insurance *as a courtesy*. However, if your insurance denies any portion of an authorized claim, you are responsible for all balances.

Insurance coverage is different for each person. It is your responsibility to check your policy for covered services, co-pay, and co-insurance amounts, and if pre-authorization is required. This should be done prior to attending the first visit. If a patient attends an appointment prior to verification/authorization, and the visit is not covered by insurance, the cost of that visit will be the patient's responsibility. Please be sure to notify our office immediately if there are any changes in your insurance coverage.

Medicare: We are a Medicare provider and will accept assignment from Medicare. There is an annual cap of \$2,230 for outpatient physical therapy. Medicare covers physical therapy and 80% of their accepted fee schedule. The patient is responsible for the remaining 20%. If there is a secondary policy to Medicare, please provide the secondary insurance information. Once the Medicare cap has been met, the patient is responsible for all future charges.

Workman's Compensation: It is imperative to supply us with a billing address for the industrial carrier, name and telephone number of the adjustor, and your claim number to ensure proper billing. You can obtain this information from your employer. We have a three strikes policy. If you miss three appointments, you will be discharged from treatment and your doctor and insurance adjustor will be notified.

Appointments: Patients are seen by appointment only. Scheduling is done on a first come, first served basis. We recommend scheduling your appointments in weekly intervals. If you need to cancel an appointment, we require at least 24 hours notice. A phone call is required to avoid a charge for a missed appointment. The charge for a missed appointment will be billed to the patient.

Doctor Appointments: A prescription for physical therapy, written by your doctor, is required by all insurances before payment will be considered. It is your responsibility that a current prescription is in out file for billing purposes. Any charges denied by insurance due to lack of a current prescription will be the patient's responsibility. Be sure to keep your follow-up appointments with your doctor. Please inform you therapist of all return doctor visits so we can send the appropriate progress reports. It is during your follow-up appointment and by communicating with your therapist, that your doctor will determine if additional therapy is appropriate.

PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS

Signature _____

Date: _____



McCarthy Physical Therapy and Sports Center

Tim B. McCarthy, P.T.

PATIENT INFORMATION ACKNOWLEDGMENT FORM

I have read and fully understand McCarthy Physical Therapy and Sports Center's Notice of Information Practices. I understand that McCarthy Physical Therapy and Sports Center may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that McCarthy Physical Therapy and Sports Center will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in McCarthy Physical Therapy and Sports Center's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name:

Signature:

Date:

McCarthy Physical Therapy and Sports Medicine, Inc.
Patient Information

Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Birth Date: _____ Age: _____ SSN: _____ - _____ - _____ Sex M F
Emergency Contact (relationship?) _____ Phone: _____

INSURANCE INFORMATION

Guarantor name and relationship: _____ Birth date: _____
Insurance Name: _____ Phone: _____
Address: _____
City: _____ State: _____ Zip: _____

SECONDARY INSURANCE

Guarantor Name: _____ Guarantor DOB _____
Insurance Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip: _____

Injury at Work? Yes No Date of Injury: _____ Motor Vehicle Accident? Yes No
Employer at time of injury: _____
Referring Doctor: _____
Diagnosis/Body Part: _____

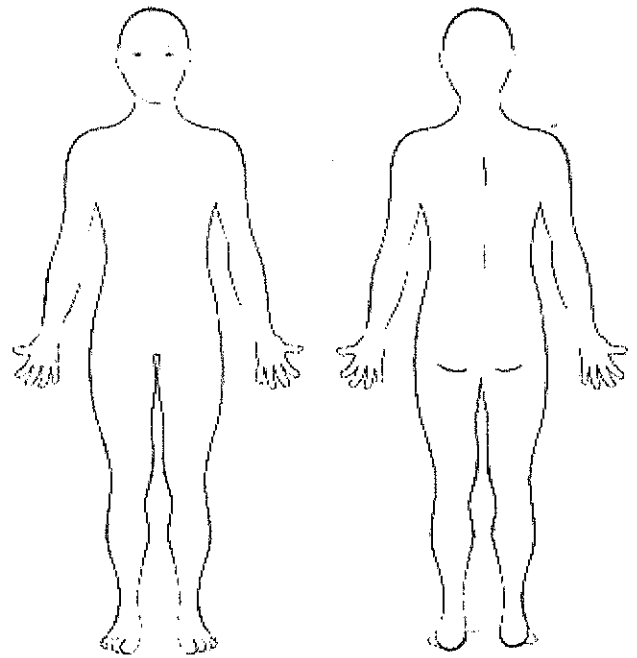
AUTHORIZATION AND ASSIGNMENT

I, the undersigned, do hereby agree and give my consent for McCarthy Physical Therapy and Sports Medicine, Inc., to furnish physical therapy evaluation and treatment considered necessary and proper in diagnosing or treating the physical condition.

I hereby assign all physical therapy benefits to McCarthy Physical Therapy and Sports Medicine, Inc. I understand that I am financially responsible for all charges. Cancellations or missed appointments with less than 24 hours advance notice to our office are subject to a \$25.00 fee. I hereby authorize release of all clinical and payment information necessary to secure payment. A photocopy shall be considered valid.

Signature: _____ Date: _____
Print: _____ Date: _____

- Y N
- Osteoporosis
 - Diabetes
 - Hypertension (High Blood Pressure)
 - Heart Disease
 - Cancer or Tumors
 - Lung Problems
 - Stomach Problems
 - Kidney or Liver Problems
 - Arthritis or other Joint Problems
 - Seizures or Nervous Disorders
 - Allergies
 - Dermatitis or any other Skin Problems
 - Eye Problems
 - Hernias
 - Unusual/Frequent Headaches
 - Are there any other health problems not mentioned above? If so please describe:



- Are you pregnant?
- Do you have any implants (i.e. joint replacements or pacemakers)?
- Are you awakened at night?
- Do you ever have uncontrolled leakage of urine, gas or feces?
- Have you ever taken medication longer than a few weeks?
- Are you currently taking any medications?
- Have you ever been hospitalized?
- Have you ever had surgery?
- Have you ever been placed in a splint, cast, ace wrap or sling?
- Have you ever had to use crutches, canes, a walker or wheelchair?
- Do you use shoe lifts, braces, corsets, or supports?
- Are you currently treated by any other doctor, therapist, chiropractor, masseuse, podiatrist, etc.?

MEDICATIONS	

Do you consider your health to be: Excellent, Good, Fair, Poor

Date of Last Physical: _____ Physician: _____ Current Physician: _____

Reason for Today's Visit: _____ Who Referred you to us? _____

Patient Signature: _____ Date: _____