BALANCE PHYSICAL THERAPY INC.
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GENERAL INTAKE FORM: FOR GENERAL INSURANCES

PATIENT INFORMATION (Please Print)

Patient's Last Name: _____ First Name: _____ Middle: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Would you like to receive email reminders? ☐ Yes ☐No Email Address: _____

Gender: _____ Date of Birth: _____

Employer Name:_____ Job Title/ Occupation: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

PRIMARY INSURANCE

Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Other Insurance Company Name_____

Subscriber's Last Name_____ First Name_____ Middle _____

Subscriber's Date of Birth _____/_____/_____ Subscriber's Employer _____

SECONDARY INSURANCE

Relationship: ☐ Self ☐ Spouse ☐ Parent ☐ Other Insurance Company Name_____

Subscriber's Last Name _____ First Name _____ Middle _____

Subscriber's Date of Birth_____/_____/_____ Subscriber's Employer _____

ADDITIONAL INFORMATION

Have you been to any other PT clinics this year, or are you currently going to any other PT clinic? ☐ Yes ☐ No # of Visits _____

***If you answered yes, please note that most insurance companies will not allow for two different physical therapy visits <u>on the same day</u>, even if they are for different issues and take place in different locations. Additionally, providers below may not be able to be seen on the same day as PT.**

Have you been to any **Chiropractic** clinics this year? ☐ Yes ☐ No # of Visits _____

Have you been to any other therapy such as **Massage, Occupational, or Speech** this year? ☐ Yes ☐ No # of Visits _____

If yes, have any of the above-mentioned visits been billed to your **<u>current</u>** insurance? ☐ Yes ☐ No # of Visits _____

For Medicare Patients: Please alert BALANCE PT if you start any other rehabilitative (PT, OT, & Speech) service while attending PT. Medicare does not allow for multiple therapy visits in the same day. Do not schedule PT visits on the same day with other PT, speech, or OT.

Have you been enrolled or are you currently enrolled in a **Home Health Care** program in the past 6 months? ☐ Yes ☐ No
If Yes, have you been or when was your **Discharge Date**: _____

Have you been enrolled or are you currently enrolled in a **Skilled Nursing Facility** in the past 6 months? ☐ Yes ☐ No
If Yes, have you been or when was your **Discharge Date:** _____

CONSENT FOR CARE:

Please read carefully and sign prior to treatment. If a copy of this release is desired, one will be provided for you.

Though it is our policy to bill the insurance carrier directly as a courtesy to our patients, please note that the patient is responsible for the entire bill when services are rendered. If, for any reason, your insurance carrier does not remit payment within 90 days of billing, the patient is responsible for the balance in full. If any payment is subsequently made by your insurance carrier in excess of the balance of your account, we will promptly refund the credit.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit the payment to BALANCE PHYSICAL THERAPY INC., PS (BALANCE PT). Once you have received a statement from BALANCE PT, all past due patient balances over 30 days will be subject to a $25.00 per month administrative late statement fee and interest charges of 12% per annum (1% per month).

Beginning 1/1/2020 we require that patients with an unmet deductible make an estimated payment of $240 per evaluation, $195 per one-hour follow up visit, or $140 per half-hour follow up visit due at the time of service. If your unmet deductible is less, we will collect your remaining deductible. This estimated payment per visit will be collected until your unmet deductible is satisfied. Once your deductible is satisfied, any estimated co-insurance and/or co-pay responsibility will be collected at time of service. All estimated payments and co-pays made in the office will not be reflected on your insurance carrier's EOB, however, monies collected at time of service will be reflected on your patient statement. If at any time it is determined that BALANCE PT has collected more than you owe, a prompt refund will be made. If amounts collected are insufficient to meet your patient responsibility, BALANCE PT will provide you a statement.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, after such default and upon referral to a collection agency or attorney by BALANCE PT, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

I hereby consent to and authorize all physical therapy treatments and procedures which may be considered advisable or necessary in the judgment of the patient's licensed physical therapist. BALANCE PT may disclose portions of the patient's records to any person, insurance company or corporation which is or may be liable for all or any portion of the charges for treatment. I assign my benefits under my medical insurance plan to BALANCE PT. A copy, facsimile, or scan of this signed document is considered as valid as, and has the same force as, the original document.

Should any provision or portion of this Agreement be held unlawful or unenforceable, the balance of this Agreement shall be nonetheless in all respects remain binding and effective and shall be construed to be in full force and effect to the extent lawfully permissible.

Patient, Parent, or Guardian Signature _____ Date _____

Printed Name: _____

Relationship to patient _____ Witness _____

UPDATED CANCELLATION POLICY FOR 2020

In order to best serve our patients, it is necessary that you give us at least a 24-hour notice of cancellation for any scheduled physical therapy appointments with BALANCE PT. Fees for **excessive** late arrivals, late cancels, and no shows will be your responsibility as follows:

- **$15 nonrefundable charge** for a 15-minute late arrival (5-20 minutes = $15 fee)
- **$30 nonrefundable charge** for a half-hour late arrival (20-35 minutes = $30 fee)
- **$30 nonrefundable charge** for a no show or late canceled half-hour appointment
- **$60 nonrefundable charge** for a no show or late canceled one-hour appointment

These **nonrefundable charges** will be billed to **you** for any appointments that are missed and not cancelled at least 24 hours prior to the appointment. These charges will **NOT** be billed to your insurance company and are your responsibility, due at your next scheduled appointment. When you have two or more no shows or late cancels you may be moved to same day scheduling. We understand that emergencies and illness do occur that are out of your control, and BALANCE PT reserves the right to waive late arrival and cancellation charges.

I agree to the above cancellation policy:_____ Date_____