Belmont Shore
PHYSICAL THERAPY

Patient Information

Patient Name:	Home Phone:
Date of Birth:	Work Phone:
Street Address:	Cell Phone:
City, State, Zip:	Soc. Sec.#:
Physician Name:	Marital Status:
Employer:	
Occupation:	
Business Address:	
City, State, Zip:	

Responsible Party

Name:	Date of Birth:
Phone:	Soc. Sec.#:
Relationship to Patient:	

Emergency Contact Information

Name:	Relationship:
Phone:	

Insurance Information

Are we treating you for an injury that occurred at your place of employment or due to a motor vehicle accident?

Yes □ No □

Primary Insurance:
Secondary Insurance:

Signature: _____ **Date:** _____

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Patient Reimbursement agreement

As a courtesy to our patients, we will contact your insurance carrier to obtain your physical therapy benefits. However, we are not accountable for the accuracy of the information provided. It is your responsibility to contact your insurance carrier to understand and confirm benefits and charges for services rendered.

If your insurance carrier fails to pay for services within 90 days, you will be billed for all unpaid charges which are due within 30 days, excluding workers' compensation patients. Failure to pay your balance will result in collection agency assignment.

At the time of service, you are responsible for payment of your annual deductible and co-payments/coinsurance.

In addition, if the deductible or out-of-pocket amount has been met during treatment. The patient will be reimbursed for any overpayment once payment is received from the insurance carrier. Please keep in mind average processing time for insurance carriers is between 30-55 days.

All insurances carriers (including Workers Compensation) will not be responsible for the purchases of supplies, Laser therapy or Cupping services from our office.

Signature: _____ **Date:** _____

Signature of Parent/Guardian: _____ **Date:** _____

Consent to physical therapy /rehabilitation services and Direct Access:

I have presented myself for rehabilitation services to Belmont Shore Physical Therapy and consent to examination and treatment provided by my attending physical therapist. I consent to the release of copies of my examination/treatment records to referring physician(s), and third-party payer (insurance companies) for the sole purpose of communication and claims processing. Also, I consent to release my medical records to an attorney and/or court order upon request. All medical records will have a printing charge and clerical fee. I authorize Belmont Shore Physical Therapy to make inquiries as it determines necessary to confirm my coverage and my financial responsibility.

I understand that I am receiving direct physical therapy treatment services and 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 me with physical therapy treatment services only after receiving, a dated signature on the physical therapist's plan of care indicating approval by the physician and surgeon or podiatrist.

Signature: _____ **Date:** _____

Signature of Parent/Guardian: _____ **Date:** _____

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Cancellation/No Show & Late Policy Terms & Conditions

Thank you for trusting your rehabilitative care to Belmont Shore Physical Therapy. When you schedule an appointment with us we set aside enough time to provide you with the highest quality care. A missed appointment interrupts your rehabilitation program, and in partnership, we become less effective in reaching your goals and the goals of your referring physician.

Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment time. This gives us time to schedule other patients who may be waiting for an appointment. Furthermore, if you are late for an appointment, you will be seen for remainder of your scheduled time so that we do not inconvenience other patients.

• Any established patient who fails to show or cancel an appointment with less than 24 hours notice will be considered a No Show and will be charged a $80.00 fee. Your Insurance (including workers' compensation) is not liable for this fee.

• Automatic patient discharge will be effective after 3 No-Shows or cancellations.

We require a credit card information to be held on file in case of any no shows or cancellations less than 24 hours notice. Please see following credit card authorization page.

I acknowledge that I have read and I agree to the terms and conditions of the Cancellation/No Show Policy.

Signature: _____ **Date:** _____

Signature of Parent/Guardian: _____ **Date:** _____

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Credit Card/ Debit Card Authorization Form

I, _____ (print name) authorize Belmont Shore Physical Therapy to charge my credit card or debit card indicated below $80.00 for each missed appointment.

This charge authorization shall remain in full force and effect until the treatment is completed.

Card Type: Visa Mastercard Discover

Credit Card Number: _____

Expiration Date: _____ Security Code: _____

Card Holders Name (Please Print): _____

Card Holders Signature (Required for Processing): _____

Billing Address: _____

City / State / Zip: _____

**Based on the HIPAA Privacy Act your credit card information will be shredded once your treatment has been completed and you are discharged from our services.