BEYOND BASICS PHYSICAL THERAPY, PLLC
1560 Broadway, Suite 311, New York NY 10036
Phone (212) 354-2622 ♦ Fax (212) 354-2752

Registration Form

PAYMENT INFORMATION		
○MasterCard ○Visa ○American Express ○Discover	Name as it appears on the card	
Credit Card Number	Expiration Date	
Billing Address	Zip	Signature

- I consent to treatment necessary for the care of the above named client/patient, and I am aware that a referral note for physical therapy is required within 10 visits or 30 days.
- I acknowledge full financial responsibility for services rendered by Beyond Basics Physical Therapy and its professional staff. I authorize Beyond Basics Physical Therapy to keep the above referenced credit card on file and charge the above referenced credit card for any and all amounts that are not paid by my insurance company within 45 days from the date of service. I agree to update and inform Beyond Basics Physical Therapy of any changes to my credit card that is on file or any changes to my health insurance.
- I understand that payment of charges incurred is due at the time of service unless other definite financial arrangements have been made prior to treatment.
- I agree to pay 1.5% interest, or a fraction thereof, each month if I fail to make payments within 30 Days of invoice or 18% annually.
- I agree to pay all attorney fees, collection fees and court costs in the event of default of payment of my charges.
- I agree that **I must cancel my appointment at least 24 HOURS** in advance. I agree that if I cancelled my appointment in less than 24 business hours in advance **I am responsible to pay $125 late cancellation fee** and I authorize Beyond Basics Physical Therapy to charge the above referenced credit card immediately after I inform the front desk ***by phone and during business*** hours about my cancellation.
- **I agree to pay a fee of $195 if I don't show up for my appointment** and I authorize Beyond Basics Physical Therapy to charge my above referenced credit card the same day.
- I understand that a phone call/email that I may receive reminding me about my appointment is just a courtesy of Beyond Basics. I agree to be completely responsible for all appointments that I make.

I have read and fully understood the above consent of treatment and financial responsibility.

Date_____ Patient Name: _____
(Please Print)

_____ _____
Patient Signature Signature of Parent or Guardian (If applicable)

BEYOND BASICS PHYSICAL THERAPY, PLLC

Financial Policy

Patient's Name _____ **DOB** ___/___/____ **Address** _____

□**AETNA/UHC (please circle one)** □**OTHER (please specify)**_____ □**Medicare** □**Self-Pay**

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies. Payment is due at the time of service unless arrangements have been made in advance. We accept Visa, MasterCard, American Express, Discover, debit cards, cash and checks. The patient is obligated to pay for late cancellation fee, no show fee, fee for arriving late, non-sufficient funds fee, and understand that these particular fees cannot be billed to any insurance companies. Deductibles are a contract responsibility between you and your insurance company.

Cancellation Fee (less than 24 hours) $125.00
No Show Fee $195.00
Non-Sufficient Funds Fee $25.00
Cancelled/Stopped Check Fee $25.00
Late fee (for each 15 minutes) $65.00

Not all insurance plans cover all services. In the event your insurance plan determines a service "not to be covered" or, if procedures to obtain coverage were not followed, you will be responsible for those charges. Please be aware that some insurance companies have a maximum number of visits and some companies also require prior-authorizations. It is the patients' responsibility to know their physical therapy benefits, check with their insurer if a prior-authorization is required, and to follow up with our office if it was obtained & visits were approved.

CO-INSURANCE PATIENTS (patients with out-of-network for UHC and Aetna-not including Aetna Chickering): After an out of network deductible has been satisfied, Beyond Basics Physical Therapy will collect a coinsurance amount from the patient. A patient with out of network benefits has a split payment, which means that the insurance company will pay the larger percentage, making the patient responsible for the smaller percentage of the visit, known as coinsurance, at the time of service. If Beyond Basics Physical Therapy does not receive payment from your insurance company within 45 days from date of service, you will be financially responsible for the remaining balance.

PATIENTS PAYING UPFRONT: we will prepare and send the claims for you, as a courtesy, in an unassigned basis. This means the insurance carrier will send the payment directly to you. Therefore, our charges for your care are due in full at the time of service. If you would rather submit the claims yourself, please let us know and we will provide you with the forms. Beyond Basics Physical Therapy extends a prompt pay discount for services rendered (see chart below), however, we reserve the right to bill the remaining balance to your insurance company. Because we balance bill your carrier, you might receive a check with a higher amount than what you've paid. It is your responsibility to endorse the balance to Beyond Basics Physical Therapy, LLC.

Medicare Patients: Medicare rates are set by US government for physical therapy, please inquire with the front desk about Medicare fees. You are expected to make payment upon receipt of services rendered. Beyond Basics Physical Therapy is a non-assigned provider of Medicare. As a courtesy, claims will be submitted on your behalf electronically. However, Beyond Basics doesn't hold any responsibility for the following: if there is any reason Medicare doesn't process the claims, time that it takes Medicare to process claims, amount that Medicare reimburses, etc. It is also your responsibility to keep track of your physical therapy visits and your yearly physical therapy cap. Please also make sure to supply us with your secondary insurance information.

FEES:

New Evaluation *$590 (60 minutes)*	Prompt Pay Discount *$295*	*Co-ins 20% *$59*	*Co-in 30% *$88*	*Co-ins 40% *$118*	*Co-Ins 50% *$147*
Treatment (45 minutes) *$390*	Prompt Pay Discount *$195*	*Co-ins 20% *$39*	*Co-in 30% *$59*	*Co-ins 40% *$78*	*Co-Ins 50% *$98*

* If your treatment time is not listed above, please inquire with the front desk about rates and fees.
*Because we require payment at the time of service, co-insurance is also discounted on a prompt pay basis.

Date_____ Patient Name: _____
(Please Print)

_____ _____
Patient Signature Signature of Parent or Guardian (If applicable)

INSURANCE BILL AUTHORIZATION FORM

I, _____ (patient name), DOB_____, hereby authorize Beyond Basics Physical Therapy, LLC, to bill/balance bill my insurance company _____ for my treatment. My Subscriber/Member ID is _____. The primary subscriber (if not myself) is _____, DOB _____.

I understand that my diagnosis will be provided to my insurer. I understand that the insurance company may request additional clinical information regarding my treatment progress in order to authorize sessions and/or payment, and I authorize Beyond Basics, LLC, to provide such information as necessary.

_____ _____

Patient or Guardian's Signature Date

BEYOND BASICS PHYSICAL THERAPY, LLC

Patient History

Name _____**DOB**_____**Physician**_____

1. Describe the current problem that brought you here?_____
_____

2. When did your problem first begin?_____
3. Rate the severity of this problem from 0 -10 with 0 is no problem and 10 being the worst _____
4. Was your first episode of the problem related to a specific incident? Yes/No
Please describe and specify _____
_____
5. Since that time it is: □the same □getting worse □getting better
Why or how?_____

6. If pain is present, rate pain on a 0-10 scale 10 being the worst._____ Describe the nature of the pain (i.e. constant burning, intermittent ache)_____
_____

7. Describe previous treatment/exercises_____
_____
Have you received physical therapy for this problem before? □ Yes □No
If yes, please list date(s) and provider _____
***MEDICARE PATIENTS:* This year have you received ANY physical therapy for ANY part of the body (neck/back/shoulder, etc.)? □ Yes □No**
IF YOU SELECTED YES, PLEASE CONTACT OUR BILLING DEPARTMENT
8. Have you had any surgeries? □ Yes □No If yes, how many____
Type of Surgery Date
_____
_____
General Health: □Excellent □Good □Average □Fair □Poor
Activity/Exercise: □None □1-2 days/week □3-4 days/week □5+ days/week
Have you ever had any of the following conditions or diagnoses? Circle all that apply

Cancer	Stroke	Emphysema/chronic bronchitis
Heart problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple sclerosis	Allergies (list below)
Ankle swelling	Head Injury	Latex sensitivity
Anemia	Osteoporosis	Hypothyroid/ Hyperthyroid
Low back pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/Tailbone pain	Fibromyalgia	Diabetes
Alcoholism/Drug problem	Arthritic conditions	Kidney disease
Childhood bladder problems	Stress fracture	Irritable Bowel Syndrome
Depression/anxiety	Acid Reflux /Belching	Hepatitis
Anorexia/bulimia	Joint Replacement	Sexually transmitted disease
Smoking history	Bone Fracture	Physical or Sexual abuse
Vision/eye problems	Sports Injuries	Raynaud's (cold hands and feet)
Hearing loss/problems	TMJ/ neck pain	Pelvic pain

Other/Describe_____

Medications - pills, injection, patch Start date Reason for taking
_____
_____
Over the counter –vitamins, etc. Start date Reason for taking
_____
_____

Date Patient/Guardian Signature:

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used or disclosed by this Practice and how you can get access to information. Please review it carefully.

LEGAL DUTY This practice is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described here.

USES AND DISCLOSURES OF HEALTH INFORMATION This practice uses your health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care that we provide. We may also use or disclose your personal health information for public health purposes, audits, emergencies and when required by law.

In any other situation, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

We may change our policy at any time. When changes are made a new Notice of Information Practices will be posted in our office and you will receive a new written notice as well.

PATIENT'S INDIVIDUAL RIGHTS You have the right to review or obtain a copy of your personal health information at any times. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. We will consider all such requests on a case by case basis, but the company is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact the Privacy Officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services.

Amy Stein, 1560 Broadway, Suite 311, New York, NY 10036 Telephone (212) 354-2622

CONSENT FORM FOR HIPAA COMPLIANCE

I have read and understand the attached **Notice of Patient Information Practices**. I understand that the company 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 company. I also understand that this practice will consider requests for restrictions 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 the Company's **Notice of Patient Information Practices**. In doing so, I hereby release Beyond Basics Physical Therapy, PLLC and I agree that a copy of this authorization may be used in place of the original.

I understand that I retain the right to revoke this consent by notifying the practice in writing at any time except for that action which has already been taken. It shall be effective only long enough to answer the purpose of which it is given and no further confidential information will be released without the execution of an additional written authorization.

ACKNOWLEDEMENT OF NOTICE OF PRIVACY PRACTICES

Date_____ Patient Name: _____
(Please Print)

_____ _____
Patient Signature Signature of Parent or Guardian (If applicable)

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Waiver of E-mail Confirmation

I, _____, am authorizing Beyond Basics Physical Therapy to use my email listed below for appointment reminder emails. Please remember this is a courtesy confirmation. I would also like to receive the Beyond Basics Physical Therapy quarterly newsletter.

Email: _____
Name: _____
Signature: _____
Date: _____