Beyond Basics Physical Therapy, PLLC
110 East 42nd Street Suite 1504 NY, NY 10017
Phone (212) 354-2622 ♦ Fax (212) 354-2752
www.beyondbasicsphysicaltherapy.com

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:
Social Security #:	CVV:	
Emergency Contact: Name:	Phone:	Relationship:

Welcome to Beyond Basics Physical Therapy!

Thank you for choosing us in your healing journey. Our mission is to enhance your overall physical health. We promise to provide you with excellent care and respect. We want you to completely understand our financial policies, so here they are:

We need your credit card on file, where we will keep it saved and safe in case we need to charge any of the following fees:

Appointment Fee	Authorizing BBPT to charge credit card on file at time of service is rendered, based on fee sheet
Cancellation Fee	60% of the booked appointment time
No Show Fee	100% of the time reserved for you on the therapist schedule
Non-Sufficient Funds Fee	$30.00
Cancelled/Stopped Check Fee	$30.00
Late fee (charged in increments of 15 minutes)	$70.00

- You can avoid the late and cancellation fees listed above. If you need to cancel your appointment, simply notify our administrative staff 24 **business** hours prior to your appointment time. To avoid the no show fee, please call the office to let us know you will not be able to make your appointment. If you are able to reschedule your appointment within the same week, you will not be charged for cancellation fee.
- If you no show or late cancel (cancel within the 24 **business** hours time frame) more than 2 times in a row, we will place you on a 48 hour cancelation policy and charge you the appointment fee at the time of scheduling.
- You will also be responsible for collection fees and court costs in the event of default of payment of charges.

I have read and fully understand Beyond Basics Physical Therapy's financial responsibility.
I acknowledge full financial responsibility for services rendered by Beyond Basics Physical Therapy and its professional staff.

Patient's Name: _____

Patient's Signature _____

Date: _____

□ Yes! I would like to receive my courtesy appointment notifications via email.
□ Yes! I would like information on seminars hosted by Beyond Basics Physical Therapy, as well as BBPT newsletters.

Email address: _____

We do not participate with any insurance. What this means is that we do not have a contract with any insurance company. Here is a brief description on how we operate with certain insurances. These are just some scenarios. If your particular insurance situation is not listed here, ask us because we are here to help you. Any questions you have can be answered during our concierge checkout after your evaluation, or at by contacting our billing manager.

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. For patients paying upfront, we provide a prompt pay discount (please see fee chart below). Prompt payment prices are only available to patients paying at the time of service. If payment is not received at the time of service, we will charge our regular fee. If you would rather submit the claims yourself, please let us know and we will provide you with the forms. If Beyond Basics Physical Therapy does not receive payment within 45 days from date of service, you will be financially responsible for the remaining balance. You will also be charged 1.5% interest, or a fraction thereof, each month if you fail to make payments within 30 days of invoice or 18% annually.

OPTIONAL CO-INSURANCE PATIENTS (United Healthcare and Aetna patients): Beyond Basics Physical Therapy will collect payment from your insurance directly once you have satisfied your deductible. You are responsible for the co-insurance based on what we bill your insurance; please see below chart fee for pricing. 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. You will also be charged 1.5% interest, or a fraction thereof, each month if you fail to make payments within 30 days of invoice or 18% annually.

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. Medicare patient have an annual physical therapy cap. Please let us know if you have or are going to physical therapy or speech therapy elsewhere, so that we can help you keep track of your Medicare cap. 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. You will also be charged 1.5% interest, or a fraction thereof, each month if you fail to make payments within 30 days of invoice or 18% annually

FEES:

Prompt Pay Discount $320 – Evaluation	*Regular price* *$475.00*	Co-ins 20% $95.00	Co-in 30% *$142.50*	Co-ins 40% *$190.00*	Co-Ins 50% *$237.50*	MEDICARE $250.00
Prompt Pay Discount $292 – 60 minute apt	*Regular price* *$420.00*	Co-ins 20% $84.00	Co-ins 30% $126.00	Co-ins 40% *$168.00*	Co-ins 50% *$210.00*	$160.00
Prompt Pay Discount $219 – 45 minute apt	*45 minute follow up* *$315.00*	Co-ins 20% $63.00	Co-in 30% *$94.50*	Co-ins 40% *$126.00*	Co-Ins 50% *$157.00*	

Please sign here to authorize us to bill your insurance company and to acknowledge that you understand the above information along with your financial responsibility.

Patients Name: _____

Patients DOB: _____

Patient's signature or guardian if applicable: _____

Date: _____

Primary Insurance Carrier: _____ **ID Number:** _____

Primary Insurance Address: _____

Secondary Insurance Carrier: _____ **ID Number:** _____

Secondary Insurance Address: _____

Patient History

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

- Describe the current problem that brought you here? _____
- When did your problem first begin? _____
- Was your first episode of the problem related to a specific incident? **Yes / No**
- Please describe and specify _____
- Since that time has the problem: □ stayed the same □ gotten worse □ gotten better
- Have you seen another provider (MD, PT, etc) for this current problem? **Yes / No**
- If Yes – Please list provider _____
- Describe previous treatment/exercises _____
- Did you get relief from the treatment(s) listed above? **Yes / No**
- Rate the severity of this problem from **0 -10**, **0** is no pain at all, **10** being the worst pain imaginable
  - Currently _____
  - At its Best _____
  - At its Worst _____
- What makes it better _____
- What makes it worse _____
- Describe the nature of the pain (i.e. constant, intermittent, burning, sharp, dull, ache) _____
- General Health: □Excellent □Good □Average □Fair □Poor
- Activity/Exercise: □None □1-2 days/week □3-4 days/week □5+ days/week
- Have you fallen in the past year? **Yes / No**
- If Yes – How many times in the past year: _____ In the past Two Years: _____
- Has a fall resulted in an injury? **Yes / No**
- If Yes – Please describe your injury _____
- Height _____ Weight _____
- Tobacco Usage / Day _____
- Has any of your medication changed recently? **Yes / No**

Medications and/or Supplements – oral, patches, injection, etc Dosage Reason for taking

(Please indicate if you have attached a separate list of Medications by checking box - ☐)

_____
_____
_____

- Have you had any surgeries? **Yes / No**

Type of Surgery Date

_____
_____
_____

Have you ever had any of the following conditions or diagnoses? Circle all that apply

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

Other: Please List _____

- **What GOALS would you like to accomplish with Physical Therapy at Beyond Basics?**

_____

MEDICARE PATIENTS:

During this calendar year - have you received ANY Physical Therapy or Speech Therapy for ANY part of the body (Neck/ Back/ Shoulder, etc.) □ Yes □No

IF YOU SELECTED YES, PLEASE CONTACT OUR BILLING DEPARTMENT

Signature: Parent/Guardian: Date:

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Consent for Physical Therapy Evaluation and Treatment

Informed consent for treatment:
The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy evaluation and treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the evaluation, treatment and options available for my condition.

Pelvic Floor Patients:
I understand that to evaluate my condition it may be necessary to have my therapist perform a pelvic floor muscle examination. This examination is performed by observing and/or palpating the perineal region including the vagina and/or rectum. This evaluation will assess skin condition, reflexes, muscle tone, length, strength and endurance, scar mobility and function of the pelvic floor region. Such evaluation may include sensors for muscle biofeedback.

Potential benefits:
I may experience an improvement in my symptoms and an increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Potential risks:
I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury. This discomfort is usually temporary; if it does not subside in 2-3 days, I agree to contact my therapist.

Alternatives:
If I do not wish to participate in the therapy program, I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Cooperation with treatment:
I understand that in order for therapy to be effective, I must come as scheduled unless there are unusual circumstances that prevent me from attending therapy. I agree to cooperate with and carry out the home program assigned to me. If I have difficulty with any part of my treatment program, I will discuss it with my therapist.

No warranty: I understand that the physical therapist cannot make any promises or guarantees regarding a cure for or improvement in my condition. I understand that my therapist will share with me her opinions regarding potential results of physical therapy treatment for my condition and will discuss all treatment options with me before I consent to treatment.

Release of medical records:
I authorize the release of my medical records to my insurance company, physicians/primary care provider or other providers that are managing my care.

I WILL INFORM MY THERAPIST OF ANY CONDITION THAT WOULD LIMIT MY ABILITY TO HAVE AN EVALUATION OR TO BE TREATED. I HEREBY REQUEST AND CONSENT TO THE EVALUATION AND TREATMENT TO BE PROVIDED BY THE THERAPIST.

Patient Name: _____ Date: _____
(Please Print)

Patient Signature: _____

Signature of Parent or Guardian (If Applicable): _____