MRPT Physical Therapy, LLC

Patient Information Form (*Please fill in form completely)* **Date**:_____

Name:_____ Date of Birth: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip:_____

Phone numbers: Home _____ Work: _____

Cell: _____ Carrier: _____ E Mail: _____
(Verizon/AT&T/T Mobile/Sprint etc)

Emergency Contact: Name: _____ Phone: _____

Primary Insurance: ☐ CIGNA ☐ United ☐ Aetna ☐ Oxford ☐ Medicare
☐ No Insurance ☐ Other_____

Referral Information:
Who referred you to us?: _____

Referring Physician: _____

Family Doctor (PCP): _____

Specialist (OB-GYN, Pain Doctor, etc): _____

Case Profile and History
Have you been treated by a Physical/Occupational Therapist this year? ☐ Yes Number of Visits _____ ☐ No

Physical/Occupational Therapist name: _____ Phone: _____

Are you **currently** being treated by a Chiropractor? ☐ Yes ☐ No Date of Last Visit:_____

Do you have (or had) any medical conditions that we should be aware of? _____
_____

Making Appointments: all physical therapy treatments are by appointment only. If you need to cancel a scheduled appointment call us 24 hours in advance. **If appointments are broken less than 24 hours in advance you will be charged a fee of $150 for the first cancellation and $250 for subsequent cancellations**.

- **Please be on time for your appointments**: if you are late we reserve the right to either, shorten your treatment time or, cancel your appointment and charge you the $150 or $250 cancellation fee.
- **We strongly recommend that you schedule as many appointments in advance as possible**. Mornings. lunchtimes and evenings are very popular appointment times and are booked on a first come, first served basis.

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for **MRPT Physical Therapy, LLC** to furnish medical care and treatment that is considered necessary and proper in diagnosing or treating my physical condition.

I UNDERSTAND THAT THIS AUTHORIZATION SHALL BE VALID UNTIL I REVOKE THE AGREEMENT THROUGH WRITTEN NOTICE TO MRPT PHYSICAL THERAPY, LLC

X _____ Date: _____ **Please Turn over**
Signature of Patient and/or Guardian

MRPT Physical Therapy, LLC

HIPAA PRIVACY STATEMENT

Our practice is committed to maintaining the privacy of your protected health information (PHI), while providing high quality medical care. In accordance with the HIPAA regulations this notice explains:

- How we may use and disclose your PHI.
- Your privacy rights regarding your PHI.
- Our obligations concerning the use and disclosure of your PHI.

We may use and disclose your PHI for treatment, payment, and health care operations (TPO).
You have the right to inspect, copy, and amend your PHI. You have the right to request restrictions on the use of your PHI. You have the right to an accounting of the disclosures of our PHI for other than TPO.

You have the right to complain about alleged violation to this practice's privacy officer and the U.S. Department of Health and Human Services. If you have questions, please feel free to meet with our privacy officer for clarification or assistance.

HIPAA COMPLIANCE AUTHORIZATION FOR DISCLOSURE AND USE OF MEDICAL RECORDS

- **I HEREBY AUTHORIZE** my Primary Care Physician or other specialist to release to **MRPT Physical Therapy, LLC** medical information such as

LAB REPORTS, X-RAY REPORTS, MRI REPORTS and all related medical information as appropriate to assist with the diagnosis and your physical therapy treatment at **MRPT Physical Therapy, LLC**.
We may need to communicate with your Primary Care Physician or other specialist concerning your treatment. Should you not wish us to communicate with your Primary Care Physician or other specialist please advise us in writing.

- **I HEREBY AUTHORIZE MRPT Physical Therapy, LLC** to disclose my medical records to my insurance company (except Medicare) for the purpose of assisting with the settlement of my insurance claims for Physical Therapy.

I UNDERSTAND THAT THIS AUTHORIZATION SHALL BE VALID UNTIL I REVOKE THE AGREEMENT THROUGH WRITTEN NOTICE TO MRPT PHYSICAL THERAPY, LLC

X _____ Date: _____
Signature of Patient and/or Guardian

Payment Agreement

I HAVE READ, UNDERSTAND AND AGREE TO THE FOLLOWING PAYMENT TERMS.

- I have chosen Marianne Ryan Physical Therapy (MRPT) as my health care provider of my own free will and am not in an emergency or urgent health situation at this time.
- I understand that MRPT is not in-network with any commercial insurer and is not enrolled as a Medicare provider, therefore I am aware that I will have to pay out of pocket at the time of service for the services I receive unless I have made other arrangements with MRPT.
- I understand that MRPT may, as a professional courtesy, provide me with a statement that I can send to my private health insurer or to directly send electronic claims to my insurer (not Medicare) so my insurer may reimburse me for any expenses that my private health insurance plan (not Medicare) covers. I also agree that no one at MRPT has made any guarantees that the services I receive at MRPT will be covered by my health plan.
- **Medicare. I** understand that since MRPT's physical therapists are *not* enrolled as Medicare providers and typically do not see Medicare beneficiaries. As such, I understand that MRPT's services will not be paid, in whole or in part, by Medicare or my Medicare supplemental insurance plan. Regardless, I have, of my own free will, asked MRPT to make an exception to their policy of not seeing Medicare beneficiaries because I want to the best care my money can buy. I understand that if I were to seek care from a Medicare enrolled provider, my services may be covered under Medicare's coverage policies but I choose to obtain my services at MRPT anyway. I am willing to pay out of pocket at the time of service and exercise my rights under the Health Insurance Portability and Accountability Act (HIPAA) to prohibit MRPT from disclosing my health records, including MRPT's billing statements, to Medicare in exchange for MRPT's willingness to accept me as their client. I understand that MRPT will not submit claims to Medicare on my behalf or provide me with a statement or billing codes that I can submit to Medicare myself. I further agree that neither I nor my caregivers, family members, authorized representatives or power of attorney will, under any circumstance, submit my claims, invoices, receipts or statements to Medicare (or my Medicare Advantage Plan) for reimbursement or to obtain a denial for a Medicare supplemental insurance plan. I agree that if I want Medicare to pay for any services that *might* be covered, I will notify MRPT so my care can be discontinued or transferred to a Medicare enrolled provider.

X _____ Date: _____
Signature of Patient and/or Guardian