



BELLE MEAD
Physical Therapy

1. **Is this condition a result of a motor vehicle accident?** **Yes** **No**

If yes, please provide the following information:

Accident State: _____ MVA Company: _____
Date of Injury: _____ Contact Name: _____
Claim #: _____ Contact Ph #: _____

****Please note that the insurance companies require that the patient have a *current prescription (within 30 days)*, a physical therapy evaluation and the referring physician's documentation in order to authorize visits for physical therapy services. Additional visits would require the same to continue with treatment. It is the patient's responsibility to make the appointment with the physician and obtain prescriptions as needed for authorized additional visits. Failure to do so can result in delayed treatment, delayed authorization/denial and non-payment of claims.**

2. **Is this condition a result of a worker's compensation injury?** **Yes** **No**

If yes, please provide the following information:

Employer: _____ WC Company: _____
Date of Injury: _____ Contact Name: _____
Claim #: _____ Contact Ph #: _____

****Please note that it is the patient's responsibility to make the appointment with the physician and obtain prescriptions as needed for visits. Failure to do so can result in delayed treatment or non-payment of claims.**

3. **Is this condition a result of a school injury?** **Yes** **No**

If yes, please provide the following information:

School: _____
Date of Injury: _____

****Please note that it is the patient's responsibility to obtain paperwork from the school for submission to the school insurance for billing. Paperwork must be completed, signed, and provided to the front desk staff in order for BMPT to submit for billing. Failure to do so can result in non-payment of claims.**

I have read and understand the above information provided to me. I agree to comply with the terms and guidelines of my insurance company.

Signature: _____

Date: _____

CONTINUED

Belle Mead Physical Therapy Insurance Updates & Financial Responsibility

MEDICARE PATIENTS:

** Please note that Medicare has very strict guidelines for physical therapy services.

- a) The patient must have a current prescription from a physician prior to initial evaluation.
- b) The initial evaluation (aka Plan of Care) is faxed to the referring physician for signature and approval of the treatment plan.
- c) Re-evaluations are performed by the therapist every 10 visits or 30 days, whichever comes first, until the Plan of Care expires.
- d) The patient must schedule an appointment with the physician and obtain a new prescription at the expiration of the Plan of Care.
- e) Medicare has a billing cap of \$2,040. Services needed beyond the cap are allowed if the condition is determined to be medically necessary. Maintenance is never allowed for physical therapy services. Treatment must be for a functional deficit and always show improvement with a reasonable date of discharge. This criteria is determined by the physical therapist and referring physician in compliance with Medicare's guidelines.

ALL OTHER INSURANCE AND SELF PAY:

Prescriptions/Referrals: It is the patient's responsibility to obtain all prescriptions and/or referrals as required by their insurance. (Please note that referrals can only come from primary care physicians.)

Authorizations: Our office will obtain any authorization required at the time of the initial evaluation. Most authorizations, depending on the carrier, require a prescription and initial evaluation for authorization requests. Authorizations are NOT a guarantee of payment. The patient is ultimately responsible for all fees incurred as well as knowing their insurance benefits.

Medical Reviews: Insurance carriers can delay claims processing pending a medical review of the treatment received. All patient documents including evaluation, re-evaluation, prescriptions, tests and treatment notes are forwarded to the requesting insurance for review. Services can be denied if determined by the insurance carrier to not be deemed medically necessary. Maintenance (services not showing significant improvement), recreational (i.e. return to sports or leisure activities) services are not considered medically necessary and can be denied.

Please be sure to always give the front desk the most updated insurance cards and prescription/referrals. Benefits for outpatient physical therapy will be verified at the initial evaluation. We strongly recommend that all patients verify their own insurance benefits prior to treatment. We are not responsible for misinformation given to us by your insurance carrier.

PATIENT FINANCIAL RESPONSIBILITY AND RELEASE:

I authorize Belle Mead Physical Therapy to furnish information to my insurance carrier(s), my primary and referring physician(s), attorney and collection agency/other party with a bona-fide interest via USPS, fax, e-mail, or written communication. My signature, scanned or copied, will be valid as the original.

I hereby assign to Belle Mead Physical Therapy all payments from medical benefits for services provided to myself or my dependents:

- I understand that all co-pays are due at time services are rendered.
- I understand that if I am a self-pay patient, the full payment is due at the time services are rendered.
- I understand that any balance on my account is due and payable upon receipt of statement.

My signature acknowledges that I understand and agree that I am responsible for all fees incurred for services provided by Belle Mead Physical Therapy that are unpaid by my insurance carrier including co-pays, coinsurance, deductibles and balances. If applicable, I understand that I am responsible for any legal fees incurred in collecting unpaid balances.

Signature: _____

Date: _____

Printed Name: _____