Linde Physical Therapy Registration Form

Patient Information

Name _____ _____ _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____

City _____ State ____ Zip _____ Home Phone _____

E-mail _____ Cell Phone _____

Sex M☐ F☐ Age _____ Birthdate _____ Marital Status M☐ S☐

Employer/School attended _____ Occupation/Grade _____

Business Address _____

City _____ State _____ Zip _____ Business Phone _____

Name of referring Physician _____ Phone _____

May I contact the above to review your case? Yes ■ No ☐

In case of emergency who should be notified? _____ Phone _____

Primary Care Physician _____ Phone _____

May I contact the above to review your case? Yes ☐ No ☐

Primary Insurance

Person responsible for account _____ _____ ____
Last Name *First Name* *Initial*

Relation to patient _____ Birthdate _____ Soc. Sec. # _____

Address(If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person responsible employed by _____ Occupation _____

Business Address _____

City _____ State _____ Zip _____ Business Phone _____

Insurance Company _____

Member ID # _____ Group # _____

Secondary Insurance

Person responsible for account _____ _____ ___
Last Name *First Name* *Initial*

Relation to patient _____ Birthdate _____ Soc. Sec. # _____

Address(If different from patient's) _____ Phone _____

City _____ State _____ Zip _____

Person responsible employed by _____ Occupation _____

Business Address _____

City _____ State _____ Zip _____ Business Phone _____

Insurance Company _____

Member ID # _____ Contract # _____ Group # _____

Assignment and Release

I, the undersigned certify that I (or my dependant) have insurance coverage with _____
Name of insurance company

and assign directly to ***Linde Physical Therapy Inc.*** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize ***Linde Physical Therapy Inc.*** to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

I also understand that should my account be placed with an agency or attorney for collection, then I agree to be responsible for all costs incurred in the collection of my account, including attorney's fees, interest at 1.5%per month (18%per anum), and all court costs.

_____ _____ _____
Responsible party signature *Relationship* *Date*

Linde Physical Therapy

3913 Old Lee Highway, Suite 31C
Fairfax, VA, 22030
Phone: (703) 877-2224
Fax: (703) 277-1962

OFFICE POLICIES

The following is a list of office policies. Please read them carefully and sign below. If you have any questions or concerns, please ask for clarification. A copy is available at your request.

Insurance:

I am only accepting a limited number of health care insurance policies. I may terminate with a company at my discretion but will give you notice of this ahead of time.

Important note: Your insurance company may decide that certain treatments are not necessary and may choose to deny payment for these services. Any treatment provided is in your best interest and is an integral part of your recovery. We will appeal this decision; however, if it is not ruled in our favor, you will be responsible for the outstanding amount.

Missed Appointments:

When you book an appointment that time is reserved for you. If you are unable to attend you are required to give 24 hours notice so that the time can be used to schedule another appointment with someone else. Failure to give this notice will result in you being billed the self-pay rate for the missed appointment. The rate for the missed appointment will be $60.00. Even if you have insurance that I accept it is your responsibility to pay for the missed appointment as your insurance will not.

Billing:

Payment is expected at the time service is rendered. In some cases a monthly statement will be sent out if discussed with me ahead of time. Failure to pay within 30 days of the statement being issued will result in no further appointments being made until such time as your account is paid in full. This policy is applied to all appointments both those attended and missed without giving notice.

If I am accepting your insurance it is expected that they will pay within 90 days of being issued the claim. Failure on their part to pay me will result in you receiving a bill for the outstanding balance. You will then have 30 days to correct this with the insurance company or pay me the outstanding balance.

Confidentiality:

All information that you provide is kept confidential. The normal ***Policy*** is to provide the referring physician and your insurance company, if they are responsible for payment of services rendered, with medical information relating to the current treatment. Your signature on the registration form allows me to provide information to the referring physician and the insurance company. Release of information to any other party would require you to sign a release of information document.

I have read the above policies and agree to comply with them.

Signature _____ Date _____

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Web Page: www.lindept.com

Verification of Benefits for Physical Therapy

*Please verify your benefits for **Physical Therapy** with your insurance company and return this form at your next visit.*

Last Name: _____ First Name: _____

Insurance Company: _____

Number of visits allowed per calender year: _____

Deductible Amount: _____

Co-pay amount: _____

Pre-authorization required? Yes ☐ No ☐

If yes, provide details:

Additional information:

MEDICARE ONLY

A. Notifier: Linde Physical Therapy

B. Patient Name: _____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare does not pay for Physical Therapy Services, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for Physical Therapy Services beyond the $1900.00 cap.

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive Physical Therapy Services beyond the $1900.00 cap
  NOTE: If you choose option 1 or 2, we may help you to use any other insurance that you may have, but Medicare cannot require us to do this.

Options: Check only one box. We cannot choose a box for you.

☐ Option 1. I want the Physical Therapy Services to continue. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare does not pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays and deductibles.

☐ Option 2. I want the Physical Therapy Services to continue, but do not bill Medicare. You may ask to be paid now, as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ Option 3. I do not want the Physical Therapy Services to continue. I understand with this choice I am NOT responsible for payment, and I cannot appeal to see if Medicare would pay.

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You may request a copy.

Signature:	Date: