INTAKE FORM

MEDICARE ASSIGNMENT AND RELEASE

I request that payment of authorized Medicare benefits be made either to me or my behalf to this office for any services furnished by that physician to me. I authorize any holder of medical information about me to release to the center for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services. If Medicare denies payment, I agree to be personally and fully responsible for payment.

FINANCIAL POLICY

I understand that I am personally responsible for direct payment of all charges incurred by me for services performed and expenses incurred on my behalf by Innovative Physical Therapy Solutions, P.C. I acknowledge that I am personally responsible for payment of invoices rendered and in the event that my health insurance carrier or other source pays a portion of the liability, I will continue to be personally responsible for the net balance due and will make timely payment. Out-of-pocket expenses such as deductibles, coinsurance, and/or co-payments are due at the time of service. In the event that my insurance company pays me directly, I hereby agree to endorse any checks sent to me for such billing to: Innovative Physical Therapy Solutions, P.C. I hereby request that my insurance carrier tender direct payment to Innovative Physical Therapy Solutions, P.C. I understand that overdue balances will incur a 2% interest charge monthly. If my account becomes delinquent and is forwarded to a collection agency, 23% of the pre-collection balance will be added to my account to cover collection expenses.

AUTHORIZATION FOR RELEASE OF RECORDS

I authorize Innovative Physical Therapy Solutions, P.C. to release requested information related to my care to my insurance company, physician, government agencies, or others responsible for my medical care.

CONSENT FOR TREATMENT

I hereby acknowledge that there have been no guaranties or assurances given to me as to the results that will be achieved due to the treatment performed by Innovative Physical Therapy Solutions, P.C. I hereby authorize Innovative Physical Therapy Solutions, P.C. to perform treatments in compliance with the treatment prescribed by my physician.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I have received a copy of Innovative Physical Therapy Solutions, P.C. notice of Privacy Practices with the effective date of April 1, 2003.

MISSED APPOINTMENT POLICY

I understand that in the instance of a cancellation without 24 hours notice, or No-Show to a scheduled appointment, Innovative Physical Therapy Solutions, P.C. reserves the right to charge a $50 fee, which is NOT covered by my health insurance plan or insurer.

NOTICE OF ADVICE FOR PATIENTS SEEKING SERVICES WITHOUT A REFERRAL/PRESCRIPTION

The Consumer Access to Physical Therapy bill, S3169/A5622, which was signed into law by Governor George Pataki July 26, 2007 allows you to directly access the services of a licensed physical therapist for 10 visits or 30 days (whichever comes first) without a referral.

I understand that the physical therapy services rendered by Innovative Physical Therapy Solutions, P.C. may NOT be covered by my health insurance plan or insurer without a referral and that such treatment may be a covered expense pursuant to a referral from a physician, dentist, podiatrist, or nurse practitioner.

PR (PUBLIC RELATIONS) MATERIAL RELEASE

I understand that the photographs, video, information and feedback given/taken at Innovative Physical Therapy Solutions, PC may be used for staff training, the development of educational materials and programs, publicity, to monitor client progress, and for other professional purposes. I, the undersigned, may be included and therefore give my consent to the preparation and use of these materials. Innovative Physical Therapy Solutions, PC has my permissions to use, distribute or publish (and to permit others to use, distribute or publish) these PR MATERIALS without restriction. This release includes a full release of liability and claims by us arising out of or related to the preparation and use of these PR MATERIALS.

I have read and fully understand and acknowledge the patient notifications and office policies of Innovative Physical Therapy Solutions, P.C.

Patient Name (First, MI, Last)_____ Date of Birth _____

_____

Patient Signature or Authorized Party – Relation to Patient (if Applicable)