KPTC
KERRVILLE
PHYSICAL THERAPY CENTER

Thank you for choosing our office! In order to serve you properly we need the following information. Please print. All information will be held confidential.

Patient Name:_____ -Male/Female- SS#_____
Date of Birth: _____ email:_____
Home Phone: _____ Cell Phone: _____
Physical Address: _____
Mailing Address:_____
City: _____ State: _____ Zip: _____
Parent's Name (If Minor): _____ Parent's SS#:_____
Name of School (If Student): _____
Referring Physician's Name:_____

PLEASE INITIAL THAT YOU HAVE READ THE ITEMS BELOW

_____ Is this a Work-Related Injury?
Yes___ (If yes please complete section underneath)
No___

WORKER'S COMPENSATION INFORMATION
Employer: _____ Address: _____
City/State/Zip: _____ Date of Accident: _____
Comp. Ins. Name: _____ Address: _____
City/State/Zip: _____ Phone: _____
Claim #:_____ Adjustor's Name: _____

_____ Are you currently under the care of a Home Healthcare Agency?
Yes___ (Medicare will not pay for Physical Therapy if you are under Home Healthcare)
No___

_____ Is this a Motor Vehicle Accident?
___Yes (Please fill out information below)
___No

MOTOR VEHICLE ACCIDENT INFORMATION
Date of Accident: _____
Responsible Parties' Insurance Information: _____

_Y / N__ Have you received any Outpatient Physical Therapy this year? If so Medicare has a cap of $1900/yr.

Signature: _____ Date: _____

INFORMATION ABOUT YOUR MEDICARE BENEFITS

If you are currently receiving Home Health Care Services, i.e. Nursing, Physical Therapy, or Occupational Therapy in your home, Medicare ***will not pay*** for your Outpatient Physical Therapy.

If a refund is requested from Medicare stating you were under the care of a Home Healthcare Agency while attending Kerrville Physical Therapy Center ***you will be responsible for the balance***.

Please check with your Home Health Agency to confirm you have been discharged before beginning any Outpatient Physical Therapy.

- Peterson Home Care (830) 257-3111
- Tri County Home Health (830) 895-3100

If you have a different agency please ask us for their contact information.

Patient's Signature_____Date_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Medication List

Medication	Dosage	Frequency	Route of Administration (Oral Etc.)

Patient Signature X _____ **Date** _____

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FINANCIAL POLICY - Page 1

(Please read and initial each of the following. Sign and date the last page.)

Thank you for choosing Kerrville Physical Therapy Center as your Physical Therapy Provider. We are committed to providing the best possible care for you. In order to achieve this goal, we need your assistance in understanding our payment policy. Please understand that payment of your bills is considered part of your treatment. The following is a statement of our Financial Policy.

PRIVATE INSURANCE

We will gladly discuss and answer any questions relating to your insurance. You must realize, however, that your insurance is a contract between you and the insurance company. We are not a party to that contract. We must emphasize that as your provider, our relationship is with you, and not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date of services rendered.

It is our policy to call and verify benefits and eligibility to estimate your payment portion. However, there is no guarantee from the insurance company of their payment amount. We may not know the exact amount due until the claim has been processed.

Regarding insurance plans where we are a participating provider, we will take the contracted rate by the insurance company and make the proper adjustments to your claim.

_____INITIALS

NON-COVERED CHARGES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You may be responsible for payment of charges denied due to the insurance company's arbitrary determination of usual and customary rates. There may also be charges that your insurance company does not cover due to limitations of your policy, or what they consider reasonable and necessary. Our goal is to improve your condition successfully based on what the doctor deems reasonable and necessary treatment. We will notify you in writing if your insurance company does not cover specific treatments that your doctor ordered. If you chose to receive the treatments that your insurance company does not cover, you will be financially responsible for the non-covered charges.

_____INITIALS

FINANCIAL POLICY - Page 2

PATIENT PAYMENT POLICY

It is the patient's responsibility to pay all copays, co-insurance, deductibles, non-covered charges, or "cash pay" estimated amounts at the time of service unless a payment plan is established.

_____INITIALS

Please select an option below:

I prefer to discuss my physical therapy benefits on my second visit **_____INITIALS**

I know my physical therapy benefits and prefer not to discuss them **_____INITIALS**

INSURANCE BENEFITS

Date: Time:

Patient Name: DOB:

Network: IN OUT

Effective Date:

Deductible Amount:

CoPay/Co-Share Amount:

Physical Therapy Cap: Dollars: Visits:

Precertification Requirements:

Out of Pocket Amount:

Lifetime Maximum:

Non-Covered Services:

Disclaimer: Based on medical necessity when claims are received. This is not a guarantee of payment. Exclusions and limitations may apply.

FINANCIAL POLICY - Page 3

The patient agrees to assign all medical benefits to Kerrville Physical Therapy Center for services provided. If I should fault or become delinquent on my account and it is sent to collections, the remaining account balance will incur a 50% surcharge to cover collection agency fees.

_____INITIAL

I have read, understand, and agree to this Financial Policy. I am also aware of, and understand my policy benefits for treatment.

Patient/Guardian Signature_____ Date_____

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PATIENT RESPONSIBILITIES

(Please read and initial each of the following. Sign and date at the bottom.)

Thank you for choosing Kerrville Physical Therapy Center for your rehabilitation needs. We strive to provide the best possible care and experience to our patients. We believe that communication with our patients regarding their responsibilities assists in providing the best service to you. We look forward to working with you on your recovery and road to "Better Health"

_____INITIAL It is the patient's responsibility to provide a current insurance card(s) at or prior to the first appointment.

_____INITIAL It is the patient's responsibility to update their insurance information, current address, and contact information for our records. Failure to do so will cause the patient to bear the responsibility for all charges.

_____INITIAL It is the patient's responsibility to inform the front desk and/or therapist if they have been seen at another clinic for Physical, Occupational, or Speech Therapy during the same calendar year. (Medicare only pays $1960 per year for Physical Therapy; You cannot see a Chiropractor and attend Physical Therapy on the same day)

_____INITIAL It is the patient's responsibility to keep, schedule, and arrive on time to appointments. Please kindly give 24 hours' notice if you must cancel an appointment. If you should fail to give notice or no-show for 3 appointments over the treatment period, you will be discharged from therapy.

_____INITIAL It is the patient's responsibility to provide a pre-authorization (if required by your insurance) or a letter of medical necessity (if required) from your physician prior to treatment.

_____INITIAL It is the patient's responsibility to inform the front desk and therapist if their treatment is the result of an auto accident or if they were injured at work. We do not bill Attorney's or accept Letter of Protections.

Patient/Guardian Signature_____ Date_____