



Thank you for choosing Physical Therapy for Women!
Jennifer R. Whaley, PT, CLT
Amanda Hromadka, DPT, CLT
Lynn E. Wozniak, PTA • Vicky McInnis, PTA
Michele Hardee, PTA
Kathleen Wilson, Office Manager
Nicole Jones & Sandy Ellsworth, Office Assistants

Date _____

New Patient Information

Patient Name: _____ / _____ / _____
(last) (first) (m.i.)

Address: _____
(street)
(city) (state) (zip code)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #: _____ Date of Birth: _____ Age: _____

Marital Status: (circle one) Married Single Divorced Widowed

Work Status: (circle one) Not employed Full time Part time Retired

Occupation: _____ Employer: _____

If you would like to be added to our email list, please fill out your email address: _____

Referring Physician: _____

Primary Care Physician: _____

How did you hear about us? (circle one)
MD Friend _____ Advertisement _____
(name) (where)

Emergency Contact: _____
(name) (phone #)

Relationship to patient: _____

Reason for Physical Therapy evaluation: _____

Date of first symptom: _____

[] I have read and understand the financial policy given to me by Physical Therapy for Women, Inc.

[] I have read and understand the HIPAA Form.

Patient signature Date

[] I would like a copy of Physical Therapy for Women, Inc's Financial Policy and/or the HIPAA Form.



Physical Therapy for Women, Inc.

Financial Policy

Thank you for choosing *Physical Therapy for Women Inc.* as your physical therapy provider. We strive to provide you with the most conservative, comprehensive level of care while respecting your individuality and current physical status. Please understand that payment of your bill is considered a part of your treatment. We require you to read and sign the following statement on our financial policy:

All patients are given the patient information form to complete prior to your evaluation. This allows us to verify your insurance coverage, therapy benefits, deductible, and co-pay information during your evaluation if at all possible. Upon confirmation of your benefits, you will be responsible for any remaining deductible, co-pay, and any non-covered services **at the time of service** unless other arrangements have been agreed upon. We will gladly file your insurance for you.

Usual and Customary Rates: *Physical Therapy for Women, Inc.* is committed to providing optimal patient care while charging what is termed “usual and customary rates.” You are responsible for payment in full regardless of any insurance company’s arbitrary determination of usual and customary rates, unless we have a current contract with your insurance carrier. You are also responsible for full payment of each visit regardless of any insurance company’s arbitrary determination of what is not medically necessary and reasonable.

Medicare: We participate with Medicare, and will file all claims as well as all supplemental policies. Federal Law mandates that all patients with Medicare must see their referring Physician every 30 days and receive a new prescription verifying the need for continued therapy. Medicare patients are required by Federal Law to pay 20% of the amount allowed by Medicare. **This is due at the time of service**, if not already satisfied with another medical provider.

Collection Charges: The patient will be held responsible for any collection charges incurred by *Physical Therapy for Women, Inc.* in pursuing payments from patients with delinquent accounts. The patient will be responsible for a **\$30.00** returned check fee.

Missed Appointments: *Physical Therapy for Women, Inc.* always reserves one full hour for each appointment/treatment session in order to provide the best level of care for our patient’s needs. If you will be unable to make a scheduled appointment, please contact us by calling (910) 798-2318 **at least 3 hours prior** to your scheduled time. This will allow us to offer that time slot to another patient in need of our services. If we are not notified as requested, *Physical Therapy for Women, Inc.* reserves the right to hold you responsible for an office visit charge of **\$50.00**.

Please let us know if you have any questions or concerns regarding our financial policy. We look forward to working with you!!



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Beth R. Fondy, PT
Lynn E. Wozniak, PTA • Vicky McInnis, PTA
Kathleen Wilson, Office Manager
Nicole Jones & Sandy Ellsworth, Off

Arboretum Centre
5919 Oleander Drive, Suite 123
Wilmington, NC 28403
Phone: (910)798-2318, Fax: (910) 798-2319

HIPAA

CONSENT TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

The Patient hereby consents to the use or disclosure of his/her individually identifiable health information ("protected health information") by **Physical Therapy For Women, Inc.** in order to carry out treatment, payment, or health care operations. The Patient should review the Facility's Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information, and the Patient has the right to review such Notice prior to signing this consent form.

Facility reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If the Facility does change the terms of its Notice of Privacy Practices, Patient may obtain a copy of the revised Notice by written request.

Patient retains the right to request that the Facility further restrict how his/her protected health information is used or disclosed to carry out treatment, payment, or health care operations. The Facility is not required to agree to such requested restrictions; however, if the Facility does agree to Patient's requested restriction(s), such restrictions are then binding on the Facility.

At all times, Patient retains the right to revoke this Consent. Such revocation must be submitted to the Facility in writing. The revocation shall be effective *except* to the extent that the Facility has already taken action in reliance on the Consent.

The Facility may refuse to treat Patient if he/she (or an authorized representative) does not sign this Consent Form (except to the extent that the Facility is required by law to treat individuals). If Patient (or authorized representative) signs this Consent Form and then revokes Consent, the Facility has the right to refuse to provide further treatment to Patient as of the time of revocation (except to the extent that the Facility is required by law to treat individuals).