**** 99 Kinderkamack Road • Suite 204 • Westwood, NJ 07675

Phone: 201.497.6211 • Fax: 201.497.6212

**PLEASE PRINT VERY CLEARLY**

Line items printed in **bold** on this page are required fields, if they apply. Thank you for your assistance.

⚫ *Patient Information*

**Name (Last, First, Middle)** Today’s Date

**Birthdate** **Soc. Sec. #** **Home Phone**

Email address Cell Phone

**Address** Work Phone

**City** **State** **Zip**

**Marital Status:** 🞏 Single 🞏 Married 🞏 Partnered 🞏 Divorced 🞏 Widowed 🞏 Separated **Sex:** 🞏 M 🞏 F

Referring Physician Phone

How did you hear about our practice?

⚫ *Primary Insurance* If you have accident, no-fault or workers compensation, please put your insurance information on the next page.

**Insurance Company**

**Insurance ID #** **Group #**

*Please enter the policyholder’s information below. If you are the policyholder yourself, check this box* 🞏 *and skip to the next section.*

**Policyholder’s Name (Last, First, Middle)**

**Relationship to Patient** **Soc. Sec. #** **Birthdate**

**Address** **Home Phone**

 **Work Phone**

⚫ *Secondary Insurance* - This section is only for patients who have Medicare as primary insurance. See Billing and Collection Policies for info.

**Insurance Company**

**Insurance ID #** **Group #**

*Please enter the policyholder’s information below. If you are the policyholder yourself, check this box* 🞏 *and skip to the next section.*

**Policyholder’s Name (Last, First, Middle)**

**Relationship to Patient** **Soc. Sec. #** **Birthdate**

**Address** **Home Phone**

 **Work Phone**

⚫ *Assignment and Release*

**I hereby authorize payment directly to Progressive Hand Therapy of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered for me or for my dependents. I authorize the providers, staff and billing agents of this practice to release any information required to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above.**

**Signature of Patient or Guardian: Date:**

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**To Be Completed By Patients Who Are Utilizing**

**No-Fault / Accident / PIP / Workers Compensation Insurance**

Was an automobile involved? If yes, were you a pedestrian or in the car?

Are you currently working? \_\_\_\_\_\_\_\_ If yes, full- or part-time? \_\_\_\_\_\_\_\_ If no, last date worked?

What date did the accident occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Carrier: Insurance Address:

Insurance Phone:

Claim Number: Policy Number:

Claims Representative: Policyholder’s Name:

Attorney’s Name: Attorney’s Address:

Attorney’s Phone Number:

Employer (if work related): Employer’s Address:

Employer Telephone:

Briefly state how the accident occurred:

I hereby authorize payment of no-fault/accident/PIP/workers compensation benefits directly to Progressive Hand Therapy.

In the event that I fail to properly file a claim for the no-fault/accident/PIP/workers compensation benefits for this illness or condition, or it is determined by the no-fault/accident/PIP/workers compensation carrier that this illness or condition is not a result of a compensable no-fault/accident/PIP/workers compensation case, or if compensation is denied because of my failure to properly execute my responsibilities (including but not limited to attending Independent Medical Examinations), I understand that I am financially responsible for all charges for all services rendered to me.

I understand that some carriers will not pay for services of more than one provider per day, and some carriers will only pay for a limited number of treatment modalities per day. I understand and agree that if my carrier attempts to enforce either or both of those policies, I am responsible for all non-covered charges, regardless of anything told to me to the contrary by me carrier.

I am responsible for payment of any deductible or coinsurance that I am held responsible for by my carrier.

I hereby give a lien on my case to Progressive Hand Therapy against any proceeds of any settlement, judgment or verdict which was paid or may be paid to my attorney(s) or myself as result of the injuries for which I have been treated or injuries in connection therewith.

I authorize the providers, staff and billing agents of this practice to release any information required to secure the payment of benefits, including to my carrier(s) and my attorney(s).

I authorize the use of my signature on all claim submissions. I authorize a copy of this document to be used in place of the original.

I have read and agreed to the above.

**Patient Name** (Please print clearly)**:**

**Signature of Patient or Guardian: Date:**

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**Billing and Collection Policies**

**Upon scheduling and registration** we require you to provide your medical insurance card, photo identification, your address, date of birth, and phone number. If you receive health benefits through a spouse, partner or parent, we require you to provide that person’s information as well. For collection purposes, we require social security numbers. Intentionally failing to notify us of changes to your insurance coverage may constitute fraud.

**Keeping appointments:** Patients must call one full business day in advance (by the same time as my appointment one business day in advance) to cancel an appointment. Failure to attend an appointment or cancellation on less than one full business days’ notice qualifies as a No Show. You may be charged $35 per No Show. (This fee does not apply to Medicare beneficiaries.) Failure to pay such charges in full may constitute breach of contract and of the provider-patient relationship, leading to your dismissal from the practice. By signing below, you accept and agree to these policies.

**Participating Insurance Plans:** We are only in-network providers with direct Medicare and some No-Fault / Accident / PIP / Workers Compensation carriers. We are not in-network with any commercial medical carriers. It is your responsibility to understand the provisions of your health insurance plan and coverage. We recommend contacting your carrier prior to receiving services in order to verify your coverage levels and responsibilities, and to all written terms and limitations of your plans prior to seeking services. You are wholly responsible for your coverage limitation, regardless of whether you are aware of the details. If you have both commercial insurance and no-fault insurance, you are responsible for providing the correct insurance at your visit. If your plan requires referrals, pre-certifications or other required documentation prior to your appointments, you are responsible for ensuring they are obtained before receiving services. If your plan requires an authorization, and you do not provide such referral, authorization or certification, you will be responsible for all charges that are not paid by your insurance carrier due to lack of authorization. By signing below you specifically agree to this, and exempt yourself from any protections your insurance plan may offer you regarding this provision. By signing below, you accept and agree to these policies.

**Out-Of-Network Insurance Plans**: If you have an insurance plan that we do not participate with, but through which you have out-of-network benefits, we may agree to file claims for services rendered, and wait for insurance carrier adjudication before billing you for the balance of the charges. Patients utilizing out-of-network benefits are responsible for paying an amount at check-in equivalent to their copayment amount (or $25 if there is no copay amount printed on the card) as patient payment toward their financial responsibility. If your plan advises us that you do not have coverage for the services rendered out-of-network, you will be billed for the entire balance. If your plan issues payment for services rendered out-of-network, you may be responsible for some or all of the remaining balance, which we will invoice you for. Balance bills are due immediately upon receipt. If your plan makes payment directly to the member or policy holder for services rendered, you are responsible to turn the entire payment over to us immediately upon receipt, by endorsing the check over to Progressive Hand Therapy, along with a complete copy of the Explanation of Benefits. (You may still be responsible for payment of some or all of the balance.) Please be advised that if you are paid by the insurer and you do not turn the payment over to us in full within 30 days, you will be assessed a 1.5% monthly interest rate, and your account may be turned over to collections (plus a 30% collection fee) and/or we may undertake legal proceedings against you. By signing below, you accept and agree to these policies.

**Custom-Fabricated Splints:** Custom splints are generally covered by Medicare, No-Fault, Accident, PIP and Workers Compensation. We will submit claims for custom splints for patients with commercial insurance as a courtesy, but require payment up-front from the patient. Should the carrier issue any payment to us for the splint, the patient will be reimbursed the lesser amount. Pricing is available upon request.

**Patient balances and payment:** It is our right and responsibility to bill you for any portion of your treatment that your health insurance carrier assigns to your responsibility, including deductible and coinsurance. It is your responsibility, as detailed by the terms of your health insurance coverage, to pay any such portion. If you do not remit payment on any such bills within a reasonable period and with reasonable notice, action against you may be pursued. If you bounce a check, you will be responsible for a $35 fee, and will not be able to pay by personal check again. You may be dismissed as a patient by our practice for failure to meet your financial obligations.

**Health insurance non-payment:** Services that have not been paid by your health insurance carrier within 60 days of claim submission, whether or not your plan is one with which we participate, wholly become your responsibility to pay in full. If your carrier later pays us for those services, you will be reimbursed for the difference. By signing below, you accept this policy.

**Self-pay patients:** If you do not have health insurance, it is our policy that you must pay for your service before leaving the office. We offer a discount for payment at the time of service which is only available on accounts which are paid in full at the time of service. A hardship discount is available for qualifying individuals upon request prior to the rendering of services.

**I have read, fully understand, accept and agree to comply with all the above policies.**

Patient Name (Please print clearly):

Signature of Patient or Guardian: Date:

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**Privacy Practices Acknowledgement and Consent Form**

♦ I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it.

♦ I agree that telephone messages regarding my appointments, prescription renewals, lab results, and all other Protected Health Information\* (“PHI”), may be left for me on voicemail systems and answering machines at the following telephone numbers, in addition to any other numbers provided to you by me:

( \_\_ \_\_ \_\_ ) \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_ Home / Office / Cell / Other:

( \_\_ \_\_ \_\_ ) \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_ Home / Office / Cell / Other:

( \_\_ \_\_ \_\_ ) \_\_ \_\_ \_\_ - \_\_ \_\_ \_\_ \_\_ Home / Office / Cell / Other:

♦ I agree that my PHI may be shared with my spouse (if applicable).

♦ I agree that my PHI may be shared with my other medical providers.

♦ I agree that my PHI may be shared with the following other people:

♦ I understand that I can change any of the foregoing agreements, at any time, by giving written notice to Progressive Hand Therapy to the attention of the HIPAA Compliance Officer.

♦ I agree that Progressive Hand Therapy may contact me at any email addresses provided to you by me regarding both PHI and non-PHI.

*\*as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time (“HIPAA”)*

Patient Name (Please print clearly):

**Signature of Patient or Guardian: Date:**

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**Patient Medical Questionnaire**

**Patient’s Name (Last, First, Middle) Today’s Date**

Please advise us of your medical history by circling Yes or No for each of the following conditions.

Heart Problems Yes No If yes, details:

Pacemaker Yes No If yes, when implanted:

High blood pressure Yes No If yes, details:

Cancer Yes No If yes, details:

Tumors or cysts removed Yes No If yes, details:

Asthma Yes No If yes, details:

Lung Disease Yes No If yes, details:

Pregnancy Yes No If yes, details:

Headaches Yes No If yes, details:

Numbness Yes No If yes, details:

Arthritis Yes No If yes, details:

Osteoporosis Yes No If yes, details:

Internal implants (metal, pins, etc.) Yes No If yes, details:

Diabetes Yes No If yes, details:

Infectious disease (hepatitis, HIV, TB, etc.) Yes No If yes, details:

Circulation problems Yes No If yes, details:

Latex allergy Yes No If yes, details:

Sensitivity to cold Yes No If yes, details:

Sensitivity to heat Yes No If yes, details:

Finger, hand or wrist surgery Yes No If yes, details:

Finger, hand or wrist fracture Yes No If yes, details:

Shoulder or elbow surgery Yes No If yes, details:

Shoulder or elbow fracture Yes No If yes, details:

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No If yes, details:

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No If yes, details:

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**Notice of Medicare Therapy Cap**

Each year, Medicare establishes a per-beneficiary cap on occupational therapy (as well as on speech-language therapy and physical therapy). What this means is that in a given year, each Medicare beneficiary is covered for those services only up to a certain dollar amount as allowed by Medicare. In 2017, for example, the cap is $1,980.

The therapy cap applies to the patient, not the provider. That means that you, as a Medicare beneficiary, are covered for this amount of services in total, spread over all your providers, per calendar year.

As a courtesy, we will attempt to determine how much of your cap you have used as of the date you begin services with us. However, if you are already receiving services elsewhere, the information we obtain from Medicare may not be up to date.

Depending on your treatment needs, the entire annual cap should allow for approximately 15-20 treatments at our practice. This number varies by patient.

If some cases, for patients whose condition qualifies under Medicare’s strict definition of severity, and for certain diagnoses, we may be able to obtain payment for services beyond the therapy cap as an exception. To do this, we may need to speak with your prescribing physician, and will need to use special codes when billing Medicare. However, at any point Medicare has the right to examine your medical file, and can decide to terminate payment for services. In addition, this exception process must be authorized by Congress each year, and while it is in place in 2017 there is no guarantee that it will continue.

The Medicare therapy caps apply to all direct Medicare beneficiaries. Some Medicare Advantage plans apply the caps, and some do not.

Any services that are rendered to Medicare beneficiaries which are not paid as a result of the therapy cap become the patient’s responsibility to pay.

**By signing below, you agree that you have read the above, that you have been notified of Medicare’s right to discontinue your treatment after the therapy cap is reached, and that you will pay Progressive Hand Therapy for any services rendered beyond the therapy cap’s coverage.**

**Patient Name** (Please print clearly)**:**

**Signature of Patient or Guardian: Date:**

Are you currently receiving home health care? Yes \_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_ If yes, details \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_