FULL CIRCLE PHYSICAL THERAPY

310 Old Country road, suite 104, Garden City, NY 11530

PHONE: (516) 741-7000 FAX: (516) 741-4002

MEDICARE

Patient Information

Last Name	**First Name**	**Middle Initial**

Address	**City/Town**	**State**	**Zip Code**

Social Security Number	**Sex**	**Date of Birth** (MM/DD/YYYY)	**Age**
- -	☐ Male ☐ Female		

Occupation	**Employer / Address**

Home Phone	**Business Phone**	**Cell Phone**
( ) - -	( ) - -	( ) - -

Insured Name/Responsible Party (Name of the person the insurance is under)	**Relationship**

Who can we thank for referring you to us?

Name of Doctor:

In case of emergency, Contact:

Name:_____ **Relationship:** _____ **Phone#:** _____

Primary Insurer *Only if other than patient*

Last Name	Middle	First Name

Address	City	State/Zip

Home Phone:	Business Phone:	Cell Phone:

Date of Birth:	Social Security Number:	Relation to Patient:

Insurance Information

Type of Injury: ❑ Personal ❑ No-Fault (Auto) ❑ Worker's Compensation

* If this is a work or auto injury, your private insurance will not pay for physical therapy services and you will be responsible for payments.

Primary Insurance Company	**Insurance ID#**
Insured's Name	Insurance Co. Phone Number
Secondary Insurance Company	**Insurance ID#**
Insured's Name	Insurance Co. Phone Number

PLEASE READ ALL FOUR OF THE STATEMENTS AND SIGN BELOW

Consent To Treatment:

I hereby grant my authorization and consent to such examination(s), treatment(s) as deemed necessary by the therapists at this facility.

Assignment of Benefits:

I authorize payment of benefits for undersigned supplier for service described.

Release of Information:

I authorize the release of any information necessary to process this claim. I also request payment of benefits either to myself or to the party who accepts assignment.

I Certify That The Above Statements Are True, And That I Will Be Responsible For Payment Of Services Not Covered By My Insurance Company.

Signed: X _____ **Date**: / /

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NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided with a copy of the ***Notice of Privacy Practices** and that I have read (or had the opportunity to read if I so choose) and understood the notice. **Attached below this packet*

_____ _____

PATIENT NAME (PLEASE PRINT) **DATE**

X _____

SIGNATURE

MEDICARE BENEFICIARIES

If you are having ANY kind of HOMECARE (skilled nursing, visiting nurse, physical/ occupational/speech therapy or home health aide etc.) you MUST inform the front desk immediately.

Your insurance (Medicare), **WILL NOT** pay for Physical Therapy services at Full Circle Physical Therapy while you are receiving any Homecare services.

Therefore, your visits at the office **WILL NOT BE COVERED AND YOU WILL BE FINANCIALLY RESPONSIBLE FOR THESE SERVICES**.

I have read the above statement. I agree and understand and I WILL inform Full Circle Physical Therapy of any Homecare services that I am receiving.

In the event that my benefits are not available for this reason under Medicare Part B, I agree that I am financially responsible.

_____ **DATE:** _____

PATIENT NAME (PRINT CLEARLY)

PATIENT SIGNATURE: X _____

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FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy that we require you to read and sign prior to any treatment.

- All patients must complete our information and insurance form before seeing the therapist.
- Medicare patients are responsible for the yearly deductible.
- If you do not have a secondary insurance, you are responsible for the 20% payment since Medicare only pays 80% of your treatment.
- We accept cash and checks.

REGARDING INSURANCE:

- We accept assignment of insurance under most plans. We cannot bill your insurance unless you give us your insurance information and an original claim form if necessary. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services not considered reasonable and necessary under the Medicare Program and/or other medical insurance. The balance due is your responsibility whether your insurance company pays or not.
- Regarding insurance plans where we are a participating provider. All co-insurance and deductibles are due at the time of treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

USUAL AND CUSTOMARY RATES:

- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

ADULT PATIENTS:

- Adult patients are responsible for full payment at the time of service.

MINOR PATIENTS:

- The accompanying adult of a minor and/or the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless payment by cash or check at time of service has been verified.

CANCELLATION POLICY:

- ***In order to be courteous to other patients, we ask that you kindly cancel your appointments within 24 hours. We will charge a $25 fee following the 1st missed visit, if we are not notified. Our office does acknowledge all extenuating circumstances and will take that into consideration when charging the fee.***

SIGNATURE OF PATIENT/RESPINSIBLE PARTY X _____ **DATE :**_____