Ideal Physical Therapy
8595 Collier Blvd, Suite 115
Naples, FL 34114 (239) 228-7473

New Patient Registration

Please Print Full Name _____ Date _____/_____/_____
First **Middle** **Last**

Social Security Number _____-_____-_____ Date of Birth _____/_____/_____ Age _____

Sex Male Female Single Married Widowed Divorced Separated

Local Address

_____
P.O. Box or Street Address City State Zip

Out of State Address

_____
P.O. Box or Street Address City State Zip

Home Phone Number (____) _____ - _____ Out Of State Phone Number (____) _____ - _____

Work Phone Number (____) _____ - _____ Mobile Cell Phone Number (____) _____ - _____

Primary Insurance _____
Guarantor _____ Relationship To Patient
_____ Are you the primary policy holder? YES NO **EMAIL:**
_____

Subscriber Name _____ Relationship To Patient _____
Subscriber Date of Birth _____/_____/_____ Subscriber SS# _____-_____-_____
Policy Number _____ Group Number _____

Secondary Insurance _____
Subscriber Name _____ Relationship To Patient _____
Subscriber Date of Birth _____/_____/_____ Subscriber SS# _____-_____-_____
Policy Number _____ Group Number _____

If this was an Accident or Workers Compensation Injury, Please complete the following information:
Insurance Company _____ Claim Number _____
Case/Claim Adjuster _____ Phone Number (_____)_____ - _____
Date of Injury _____/_____/_____ **Auto Fall Work Accident Other**
Notify In Case of Emergency _____ Phone Number (_____)_____ -_____

I understand that if I do not cancel an appointment 24 hours in advance,
I will be charged a $25.00 Cancellation Fee.

_____ _____
Patient / Subscriber Signature Date

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Medical History

Patient Name: ________________________________ **Date:** __________________

Medical Condition	***Date of 1st Occurrence***		***Date of 1st Occurrence***
Cardiac Arrhythmia	________________	Stroke	__________________
Diabetes	________________	Pacemaker	__________________
Osteoarthritis	________________	Osteoporosis	__________________
Asthma	________________	Other	__________________
Cancer	________________	______________________________	
High Cholesterol	________________	______________________________	

Surgical History	***Date of Surgery***		***Date of Surgery***
Knee Surgery	________________	Back Surgery	____________________
Shoulder Surgery	________________	Neck Surgery	____________________
CABG (Open Heart)	________________	Cancer Removal	__________________
Total Hip Replacement (L or R)	_______________	Other	___________________________
Total Knee Replacement (L or R)	______________		

____

Medications

Current Medications	**Reason**	**Dosage**	**Frequency:** (Circle)	**Type** (Circle)
________________	___________	_________	1/Day 2/Day 3/Day or As Needed	Oral/Inject
________________	___________	_________	1/Day 2/Day 3/Day or As Needed	Oral/Inject
________________	___________	_________	1/Day 2/Day 3/Day or As Needed	Oral/Inject
________________	___________	_________	1/Day 2/Day 3/Day or As Needed	Oral/Inject
________________	___________	_________	1/Day 2/Day 3/Day or As Needed	Oral/Inject
________________	___________	_________	1/Day 2/Day 3/Day or As Needed	Oral/Inject
________________	___________	_________	1/Day 2/Day 3/Day or As Needed	Oral/Inject
________________	___________	_________	1/Day 2/Day 3/Day or As Needed	Oral/Inject
________________	___________	_________	1/Day 2/Day 3/Day or As Needed	Oral/Inject
________________	___________	_________	1/Day 2/Day 3/Day or As Needed	Oral/Inject

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Treatments Related to Current Condition

Type of Treatment (mark all that apply)	**Start Date**	**End Date**	**Improved**
Home Health	___________	___________	Y N
Primary Physician	___________	___________	Y N
Orthopedic Surgeon	___________	___________	Y N
Physical Therapy	___________	___________	Y N
Diagnostic Imaging (MRI, X-ray)	___________	___________	Y N
Chiropractor	___________	___________	Y N
Neurologist	___________	___________	Y N
Physiatrist	___________	___________	Y N
Massage	___________	___________	Y N
Other ________________________	___________	___________	Y N

IDEAL PHYSICAL THERAPY
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Insurance Assignment/Authorization to Release Confidential Consent for Treatment

1. _____ (Initials) I give my consent for a physical therapy evaluation and treatment to be administered by Ideal Physical Therapy.

2. _____ (Initials) I authorize my medical information to be released from my chart to my physician and in addition to any third-party billing company working with or on behalf of Ideal Physical Therapy in efforts to bill my insurance company.

3. _____ (Initials) If this is a workman's compensation claim or a motor vehicle claim, I authorize the release of information to claim adjusters, case managers and employers as needed. This is to includes any attorneys involved.

4. _____ (Initials) I understand that I am responsible for payment of services rendered. Billing will be done from this office to my insurance carrier and I am responsible for my deductible. I am aware that I am responsible for co-payment amounts dictated by my insurance carrier. I will be charged "usual and customary amounts" based on the fee schedule for rehabilitation that my insurance carrier has developed or allowed.

5. _____ (Initials) I understand that Ideal Physical Therapy, will verify my insurance benefits as a ***courtesy*** to me and collect Copayments, Coinsurance and Deductibles based on *estimates* only provided by my insurance carrier. Should my insurance carrier deny or make only a partial payment, I understand that I am responsible for any remaining balances.

6. _____ (Initials) I authorize my insurance carrier to directly pay Ideal Physical Therapy, for services appropriately rendered and billed for.

7. _____ (Initials) I recognized that it is my responsibility to remit checks issued directly to me from my insurance carrier to Ideal Physical Therapy, If my insurance carrier issues payment to me for services rendered and I have a remaining balance with Ideal Physical Therapy, I understand that it is my responsibility to not only turn over the payment but that I am responsible for any remaining balances not covered by my insurance carrier.

8. _____ (Initials) **I understand that should I not provide 24 hours notice to Ideal Physical Therapy, to cancel my appointment, I will be charged a No Show/Cancellation fee of $25.00, which cannot be waived.**

This Insurance Assignment/Authorization to Release Confidential Information/Consent for Treatment is applicable to all Ideal Physical Therapy, LLC. office locations.

A. Notifier: IDEAL PHYSICAL THERAPY

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D. Physical Therapy Services** below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D. Physical Therapy Services** below.

D. Physical Therapy Services	E. Reason Medicare May Not Pay:	F. Estimated Cost
97161, 97162, 97163, 97530, 97150, 97112, 97140, 97035, 97116, G0283 Physical Therapy and Evaluation treatment.	Annual $3,000.00 Threshold for PT and SLP services has been reached or exceeded.	$105.35 for each visit/ date of service.

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. Physical Therapy Service** listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D. Physical Therapy Services** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D. Physical Therapy Services** listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D. Physical Therapy Services** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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