Advance At Home
Physical Therapy House Calls

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www.AdvanceAtHomePT.com

NEW PATIENT CONSENT FORM

"Personalized Care with Specialized Therapists"
Serving: Nassau, Suffolk, Queens & Manhattan

NEW PATIENT CONSENT FORM

Thank You for choosing Advance at Home Physical Therapy, P.C. We are committed to providing you with the best possible medical care. Please carefully read the following, and sign below.

We will do our best to verify that we can treat you. This is however, no guaranty of benefit. It is your responsibility to know your insurance policy and initiate a referral when necessary. Any questions regarding your policy deductibles and co-pay should be referred to your insurance company.

- **INSURANCE**: Your insurance is a contract between you and your insurance company, and we are not a party to that contract. For those patients whose plans accept Advance at Home Physical Therapy P.C. as a contract provider, we will submit the appropriate claim to your carrier. AFTER our office has received payment from your insurance company and all appropriate adjustments have been made, YOUR remaining balance will be billed to you and is then **due and payable upon receipt of the bill**. In the event your insurance company requests a refund or denial of payments, you will be responsible for the amount of money refunded or due for services provided. Be advised our services may be **Out of Network** for your policy, which could result in you having to meet an additional deductible.
- **PAYMENT FOR SERVICES**: payment is due at the time services are rendered or upon receipt of the patient billing statement. In order to expedite this payment we accept cash or personal check.
- **RETURNED CHECKS**: There is a $25 fee for all returned checks.
- **ASSIGNMENT OF BENEFITS**: I hereby authorize Advance at Home Physical Therapy P.C. to bill my insurance company and for my insurance company to remit payments to Advance at Home Physical Therapy P.C. for services rendered.
- **PROTECTION OF PATIENT INFORMATION**: Please understand your patient information is held in confidences and that no information will be given out without your direct consent. By signing this form I acknowledge the notice of privacy practices and give permission to use information solely for the purpose of collection of claims. If information is requested by anyone or company other than your insurance or yourself, you will need to provide us with a release of information form in writing.
- **CONSENT TO EVALUATION AND TREATMENT:** I do hereby consent to the evaluation and treatment by Advance at Home Physical Therapy P.C. I understand it is my right to accept or refuse any treatment offered me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

*Important: If you enroll or are currently with a Home Health Care agency, our physical therapy services will NOT be covered until you are discharged from that Home Health Care Agency. If this happens, you will be responsible for the cost of the Physical Therapy services (up to $125.00 per visit). To receive services through Medicare, you must check all off the following:

- ☐ I am not seeing a nurse in my home
- ☐ I am not seeing a social worker in my house
- ☐ I am not receiving wound care
- ☐ I am not receiving physical, occupational, or speech therapy

I have read and understand the above information. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient Signature or Responsible Party: _____ Date/Time Field _____

Representative/Witness Signature: _____ Date/Time Field _____

Email Form | Print Form