Forever Fit
PHYSICAL THERAPY & WELLNESS

Patient Name/Guardian Name_____ **Date**_____

_____ **Private Insurance** – "Forever Fit" will bill your primary insurance company for you. Before initiating physical therapy services, treatments and procedures, we will verify your insurance benefits for you. Please note, while we take reasonable action to obtain accurate coverage information from your insurance company, this is not a guarantee of payment. It is your responsibility to know your benefits and follow your insurance company's requirements. **It is also your responsibility (if a referral is required based on your insurance plan), to make sure that we have a current referral to cover each visit.** *You will be responsible to pay all patient portions (co-pay, co-insurance, deductible) of treatment upfront at the time of treatment unless other arrangements are made in advance.* You will also be responsible for payment of all non-covered services.

Insurance _____ Deductible_____Amount met_____Co-insurance_____ Co-pay_____

Number of visits per year_____ Documentation required_____

_____**Medicare** - "Forever Fit" will bill Medicare for you. In most cases, Medicare will pay 80% of charges and you will be responsible for the remaining 20%. Please note, Medicare Part B has an annual ***deductible*** **of** _____ that you must pay before they pay the 80%. If you have a secondary insurance company we will verify your benefit and bill the balance to your secondary insurance.

_____**Worker's Compensation** - "Forever Fit" will bill your workers compensation company for your claim. Please note, if authorization of visits is required, we will **NOT** treat you without authorization from your adjuster *unless you have health insurance* to cover any denied treatments OR you pay UPFRONT for your treatment. Authorization of visits is not a guarantee of payment. If your treatment is denied, you will remain responsible for all charges.

_____**Auto Insurance -** "Forever Fit" will bill YOUR automobile insurance company for treatment **resulting from any auto accident regardless of fault**, as required by Maryland state law. Auto insurance policies have limits of Personal Injury Protection coverage and it is the insured's responsibility to know those limits. Any charges beyond that limit are the responsibility of the patient. It is "Forever Fit" 's policy to bill the patient's medical insurance or to collect payment upfront for any charges beyond PIP limits**. If PIP checks are sent directly to you, the patient, you have 3 business days to turn them over to "Forever Fit".**

_____**Legal Suit** - It is "Forever Fit" 's policy not to wait for court settlement or adjudication for payment of account balances. We will consider a legal letter of protection **if all** the following criteria are met:

1. The patient is not covered under health or auto insurance
2. The patient is awaiting settlement or adjudication and subsequent payment of damages from a related legal case
3. An authorization and assignment form is signed by both patient and attorney PRIOR to initiating care YOU

WILL BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES NOT COVERED BY ANY SETTLEMENT OR ADJUDICATION.

Delinquent Accounts - Payment of your balance is due in full 30 days from the date of invoice. Any accounts over 90 days old may be forwarded to a collections service/attorney. We reserve the right to pass any cost of recovering this debt, including but not limited to, collection service fees, attorney fees and court costs to the patient/guarantor.

_____**Missed Appointment Fee** - 24 hour notice is required for all canceled appointments. Any appointments canceled with less than 24 hour notice, or no-show appointments will be charged a $30.00 fee, DUE AT THE TIME OF NEXT APPOINTMENT BEFORE TREATMENT. *Please note, your insurance company or worker's compensation company will NOT pay this fee.*

_____***Health Information Privacy and Protection Act Policy -*** by initialing here I am indicating that the formal office HIPAA policy, also called Notice of Privacy Practices, was offered to me and I have been provided an opportunity to review it. I am aware that I am entitled to a copy of this notice and that I have the opportunity to review it every three years upon my request.

_____**Consent to Treatment and Waiver of Liability** - I do hereby consent to such treatment by the authorized personnel of Forever Fit Physical Therapy & Wellness, LLC as may be dictated by prudent medical practice for my illness, injury or condition.

_____ _____

Signature of Patient/Guardian Date

Billing Policy, Release and Authorization

I authorize Forever Fit Physical Therapy & Wellness, LLC to bill my insurance company directly for all services provided and I authorize payment of medical benefits directly to Forever Fit Physical Therapy & Wellness, LLC. I authorize Forever Fit Physical Therapy & Wellness, LLC to release all information necessary to secure payment for such services. I understand that I am responsible for all charges, whether or not paid by insurance company, as well as any reasonable collection fees, attorney fees or court costs associated with the recovery of this debt. I understand that some insurance companies require pre-authorization for treatment or have reimbursement/visit limits on physical therapy treatment and that it is my responsibility to know and meet those requirements.

*I hereby acknowledge that I understand and have been informed of the reasons for the treatment, care and/or procedures along with the expected benefit, risks, and possible consequences and to the maximum extent permitted by applicable law, I do hereby, for myself, my heirs, executors, and administrators, waive, release and forever discharge Forever Fit Physical Therapy & Wellness LLC and its personnel and employees from any and all claims, demands, actions, or causes of action on account of any injury to me which may occur as a result of such treatment, care and procedures except for intentional and/or negligent acts which solely and directly cause such injury by such personnel and/or employees.

_____

Signature of Patient/Guardian Date

FOREVER FIT PHYSICAL THERAPY & WELLNESS LLC

3901 National Drive, Suite 100, Burtonsville, Maryland 20866

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, **Forever Fit Physical Therapy & Wellness** (The Company) creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among The Company's personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill.
I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for The Company that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that The Company may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that The Company is not required to agree to the restrictions requested. The procedure to request restrictions on information use and disclosure is contained in the Notice of Privacy Practices.

I acknowledge that I have received a copy of the Notice of Privacy Practices of Forever Fit Physical Therapy & Wellness and agree to the liability limitations explained therein.

Signature of patient or legal representative	Date	Relationship to Patient

Printed name of patient
Effective date April 14, 2003
Revised date September 23, 2013

Forever Fit
PHYSICAL THERAPY & WELLNESS

Patient's Name: _____ Date of Birth: _____ TODAY'S DATE: _____

Please circle any of the below conditions you have now or have had in the past:

Allergies:	Depression	Multiple Sclerosis
Anemia	Diabetes Controlled/Uncontrolled	Osteoporosis
Anxiety	Dizzy Spells	Parkinsons
Arthritis	Emphysema/Bronchitis	Rheumatoid Arthritis
Asthma	Fibromyalgia	Seizures
Autoimmune Disorder	Fractures	Smoking
Cancer Specify:	Gallbladder Problems	Speech Problems
Cardiac Conditions	Hepatitis	Strokes
Cardiac Pacemaker	High Blood Pressure Controlled/Uncontrolled	Thyroid Disease
Chemical Dependency	Incontinence	Tuberculosis
Circulation Problems Currently Pregnant Hearing Impairment	Kidney Problems Metal Implants High Cholesterol	Vision Problems Headaches HIV/AIDS
MRSA Blood Clot/DVT	Muscular Disease	OTHER

Describe any other conditions and surgical history:

_____

_____

Have you had an injury as a result of a fall in the last year? Yes No Height:_____ _ Weight:_____

Two or more falls in the last year? Yes No

Are you on Blood Thinners? Yes No

Are you Allergic to Latex? Yes No

Current Complaints: (what brings you to therapy today) Date of Onset_____

_____

_____

Have you experienced any of the below symptoms/problems in the past 2 weeks? (Circle if yes)

Dizziness/ Vertigo	Headaches	Difficulty Swallowing	Unrelenting Night Pain
Unexplained Weight Loss	Urinary or Fecal Incontinence	Fever/Chills	Numbness/Tingling in arms/legs

Please list any medications you are currently taking (& dosage if known):

_____

_____

I certify that the above is true to the best of my knowledge. Patient signature: _____

Reviewed by Physical Therapist_____ Date: _____