Moscow Mountain Sport & Physical Therapy (MMSPT)

_____**Billing Insurance:** MMSPT will bill the insurance provider for services. If MMSPT is provided incorrect insurance information and/or insurance coverage has been terminated, the patient will be financially responsible for services. MMSPT will provide reasonable efforts to obtain insurance authorization for services, however it is the patient's responsibility to know and verify insurance coverage and pre-authorizations. If the insurance company fails to pay the claim(s) in a timely manner or rejects the claim in part, or in full, the patient is financially responsible.

_____**Cancellation / No Show Policy:** MMPST respects and values your time. Please allow sufficient notice so we will be able to offer your appointment to someone else. We require 24 hour notice for cancellations.

- After the first no-show or cancellation with less than 24 hour notice (late cancellation) patient will be notified of failing to comply with policy
- After 2nd no-show or late cancellation, the patient will be billed $25
- After the 3rd no-show or late cancellation, the patient will be billed $25 and any future appointments will be removed from our schedule.

*We understand that emergencies or other situations arise. Those situations will be considered by our office manager / clinic owners on a case-by-case basis.

_____**Co-Pays**

- Per visit co-pays are expected to be paid at <u>each</u> appointment.

_____ **Deductible Not Met**

- Patients with a deductible greater than $250.00 who have not yet met that deductible will be required to make a minimum payment of <u>$40</u> each visit towards the accruing balance until their deductible is reached and insurance payment begins. The patient will be billed the remaining balance.

_____**Cash Discount / Direct Pay Program**

- MMSPT offers special rates when a patient pays directly without us billing an insurance company
    - First appointment: Includes evaluation, treatment plan and initial treatment: $135
    - 45 minute follow-up appointment: $95
    - 30 minute follow-up appointment: $65

Payment is expected at each appointment.

_____**Delinquent Accounts / Payment Plans**

- The patient is financially responsible for the costs of collection on the account, including reasonable attorney fees and costs we incur for delinquent accounts. Accounts greater than 60 days will accrue 3% interest. Delinquent accounts will be sent to collections. Returned checks are charged $30.
- MMSPT accepts cash, check, credit card and Care Credit. We also allow for a payment plan, however only through our online bill pay program **www.securebillpay.net/moscowpt**. Our online payment program allows a credit card to be entered and payments are automatically withdrawn.

_____**HIPAA:** In compliance with HIPAA, our notice of privacy practices must be made to all patients. MMSPT has a responsibility to protect the privacy of your protected health information. Our notice of privacy practices describes how your protected health information may be used or disclosed, how you can access your information and who to contact if you have questions or concerns. I acknowledge receipt of this office's notice of privacy practices. I have received/reviewed a copy for my records.

I have read and agree with the terms in this agreement. I consent to receive Physical and/or Occupational Therapy care at Moscow Mountain Sport & Physical Therapy.

_____ _____

Signature of Patient Date Printed Name of Patient

I have read and agree to the terms of this statement and further agree to be jointly liable for services rendered to the above named patient.

_____ _____

Signature of Parent/Guardian Date Printed Name of Parent/Guardian

Moscow Mountain Sport & Physical Therapy

General/Demographic Information:

Patient Name (First Middle Last) :_____

Date of Birth:_____ Age:_____ Sex: ☐Male ☐Female ☐ Married ☐ Single ☐ Widowed

Mailing Address:_____ City:_____ State:_____ Zip:_____

Permanent Address:_____ City:_____ State:_____ Zip:_____

Home Phone Number: _____ Cell Phone_____ Work Phone:_____

Email Address:_____ Occupation:_____

Primary Physician:_____ Referring Physician:_____

Do we have permission to send you text reminders? ☐ Yes ☐ No

Do we have your permission to send you email reminders? ☐ Yes ☐ No

Preferred method for appointment reminders: ☐ Text ☐ Email ☐ Phone call

If not the patient, who is financially responsible? _____Relationship: _____

Address of responsible party: _____Phone: _____

****PLEASE NOTE: for patients over 18, federal law requires us to have a signed consent by the patient to provide any medical or billing information to anyone other than the patient, *including the parents* who are providing the insurance.**

Insurance Information: If you provide us with a copy of your insurance card, you do not need to complete this section.

Primary Insurance: _____ Policy #: _____Secondary Insurance: _____ Policy #: _____

Do you require care due to an accident? If yes, what type of accident?

☐ Work ☐ Auto ☐ Sport ☐ Other, please explain: _____

If work or motor vehicle accident, name of insurance company: _____

Claim number: _____Date of Injury: _____

Medical History:

What brings you to Physical Therapy today? _____

What is your main goal in coming to therapy? _____

What other treatments have you tried for this problem? (Medications, ice, etc.)_____

_____

Date of Onset of Symptoms: _____ Surgery Date (if applicable): _____

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

Medications: If you are unsure of the name of your medication, a generic description or name is acceptable.

Name	Dosage	Frequency	Form
		x per Day	Oral Other: _____
		x per Day	Oral Other: _____
		x per Day	Oral Other: _____
		x per Day	Oral Other: _____
		x per Day	Oral Other: _____
		x per Day	Oral Other: _____
		x per Day	Oral Other: _____

Thank you for coming to Moscow Mountain Sport & Physical Therapy.

Once you are finished completing these forms, please promptly return them to the front office staff. –MMSPT