Therapy Treatment Agreement – Flaming Physical Therapy

11 Elsinore Avenue, Bath, Maine 207-442-9810
68 Chapman Street, Damariscotta, Maine 207-563-7990

This document is a treatment agreement in which the patient, or the responsible party for the patient, and Flaming Physical Therapy are identified below. The patient, or responsible party, consents to evaluations and treatments upon the provisions hereof, and patient, responsible party and Flaming Physical Therapy hereby agree with each other as follows:

PATIENT NAME; LAST ___________________________ FIRST ____________________ MI ___

Date of Birth ____ / ____ / _______

ADDRESS: ____

CITY: ______________________ State: ______________ Zip Code: __________

Billing Address ____ (If Different from above)

PHONE: Home: ____________________ Cell: _________________ Other: ______________

E-MAIL: ____

Gender: Male: ______ Female: ______

Marital Status: Married: _____ Single: ______ Other: ______

WORK STATUS: Employed: ____ Unemployed: ____ F/T Student: ____ Retired: ____

Employer: ____

RELATIONSHIP TO SUBSCRIBER: Self: ____ Spouse: ____ Child: ____ Other: ____

IF Someone other than the patient is the subscriber; Please fill out below:

Name of Subscriber ______________________________ Subscriber Birth Date: ___ / ___ /___

Address (if different) __________________________________ Phone: ____________________

Employer of Insured ____

EMERGENCY CONTACT ____________________________________ Phone _______________________

Is the Patient Condition related to (or results of) any of the Following?

Employment? YES ____ NO ____ If YES, is this Workers Compensation? _______

Auto Accident YES ____ NO ____ IF YES, who's Insurance is Responsible? ______

Other Accident YES ____ NO ____ If YES, Which Insurance is Responsible? ______

Use Space Below to Explain:

DIAGNOSIS of Injury / Illness / Surgery: ______________________________________

Date of Current Injury / Surgery / other: ____ / ____ / ______

Date P.T. Ordered: ____ / ____ / ______

Patient's Next Physician Follow up visit ____ / ____ / ______

PRIMARY PHYSICIAN: ___________________________________ Phone#: ___________________

Ordering Physician: __________________________________ Phone#: ___________________

PRIMARY INSURANCE: _________________________________ Plan Name: __________________

ID Number: ____ Group#: _____________________

Claims Mailing Address: ____

Co-Payment Amount for Physical Therapy: ______________ Deductible: ____________________

SECONDARY INSURANCE: ______________________________ Plan Name: __________________

ID Number: ____ Group#: _____________________

Claims Mailing Address: ____

CO-PAYMENTS ARE COLLECTED AT EACH VISIT. YOU WILL BE BILLED FOR ANY COINSURANCE BALANCE AS INDICATED BY YOUR INSURANCE PLAN. IT IS YOUR RESPONSIBILITY TO KNOW YOUR COINSURANCE.

AUTHORIZATION for RELEASE OF INFORMATION: The institution rendering services is hereby authorized to furnish and release, in accordance with facility policy, such professional and clinical information as may be necessary for the completion of my medical claims by valid third party, agents or agencies from the medical records compiled during treatment. The facility is hereby released from all legal liability that may arise from the release of said information.

TREATMENT CONSENT: I, the undersigned, so hereby agree and give my consent and authorization for Glenn Flaming Physical Therapy to provide examination, treatments and services to myself/designee. I realize and certify that no guarantee or assurance has been made as to the results that may be obtained for such examinations, treatments and services.

ASSIGNMENT AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I hereby assign and authorize payment directly to this facility, herein specified and otherwise payable to me, but not to exceed the facility's regular charges for this period of treatment. I understand I am responsible to the facility for the charges NOT covered NOR paid by my Insurance, or through Worker's Compensation.

CANCELLATION / NO SHOW POLICY: Your well being is our highest concern. For you to benefit from your Physical Therapy treatment, we encourage you to keep each scheduled appointment. We realize that this is not always possible. Therefore, if you must cancel, we ask that you call the office at least 24 hours prior to the scheduled appointment time. Failure to cancel within the allotted time frame mentioned **will result in a $50.00 charge**, or the amount of your co-pay, **WHICH EVER IS THE GREATER AMOUNT**. This charge will be collected at the next scheduled appointment or will be billed to you upon Discharge. As always, we are glad to answer any questions and work with you if you have special circumstances. **Ongoing failure to keep your appointments may result in decision to terminate your therapy with us.**

PATIENT (or GUARDIAN) Signature: ____________________________________ Date:_________________