Blake & Associates, Inc.
Physical Therapy

5754 Bridgetown Road • Cincinnati, OH 45248
(513) 661-6555 • Fax (513) 661-6556 • www.blakeandassociatespt.com

Date

PERSONAL INFORMATION

Name (First, MI, Last) | SSN | Age | DOB | Sex | Marital Status

Home Street Address | City | State | Zip

Home Phone | Work Phone | Cell Phone | E-Mail Address

Emergency Contact Name/Relationship | Emergency Contact Phone | Alternate Phone #

Referring Physician | Family Physician | Date of Injury

Employer | Occupation

INSURANCE INFORMATION

Is this condition due to a work related injury? ____ Claim # _____ Date of Injury _____

Is this a litigation (are attorney's involved)? ____ Attorney _____ Phone # _____

Primary Insurance Company | Policy/ID Number | Policy Holder's Name

Policy Holder's SSN | Policy Holder's DOB | Relationship to Patient | Policy Holder's Employer

Secondary Insurance Company | Policy/ID Number | Policy Holder's Name

Policy Holder's SSN | Policy Holders DOB | Relationship to Patient | Policy Holder's Employer

RESPONSIBLE PARTY

Name (If other than patient) | DOB | SSN

Street Address | City | State | Zip

Home Phone | Work Phone | Cell Phone | Employer

How may we contact you? (Check all that apply) Home Work Cell E-mail Answering Machine

I authorize Blake & Associates, Inc. to discuss my health information with the following individual(s): _____

How did you hear about us? Phone book Internet Physician Friend Other _____

Can we thank someone for your referral to us? _____

CONSENT TO TREATMENT

- I understand the Physical Therapy Treatment/Evaluation as explained to me and give my consent to such treatment.
- I authorize Blake & Associates, Inc. to release my medical information necessary to process this claim.
- I hereby assign all medical benefits to which I am entitled to Blake & Associates, Inc. This assignment will remain in effect until revoking by me in writing. A photocopy of this assignment is to be considered as valid as an original.

* The parent bringing a child in for treatment is responsible for all fees incurred regardless of divorce decree.

Signature Date

ACKNOWLEGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have read Blake & Associates, Inc.'s notice of Privacy Practices.

Signature Date

FINANCIAL POLICY

It is our belief that patients are responsible for payment of fees charged for services rendered. If there is not insurance coverage, payment is expected at the time of treatment. Cash, personal checks, Visa, Mastercard, American Express and Discover are accepted.

NEW PATIENTS: We charge an annual processing fee of $25.00 for all new evaluations. This amount is due before treatment can begin. We do not bill insurance for this fee.

INSURANCE: We file insurance claims daily. Co-pays are due at the time of service. Co-insurance will be requested after the payment from insurance is received. The patient is ultimately responsible for any amounts not covered by insurance. The balance of all charges not paid or covered by insurance will be charged to your credit card on file (See Easy Pay Consent). If no credit card is on file, you agree to maintain a zero balance. Interest is added to accounts with balances over 30 days old. If an account is forwarded to 3rd party intervention, the patient is responsible for all collection costs.

WORKERS COMPENSATION: We bill the Bureau of Workers' Compensation daily. Your referring physician must request treatment and authorization from BWC and this authorization must be received before treatment is possible. However; the patient is ultimately responsible for any claims denied by Workers' Compensation.

AUTOMOBILE INSURANCE: As a courtesy, we bill automobile insurance. We find it a financial burden to wait for settlement; therefore if payment is not received from your insurance company within 30-45 days, you will be responsible for payment.

MEDICARE: We are a certified provider of services for Medicare patients. We take assignment and bill Medicare accepting reimbursement at levels established by Medicare. As a Medicare patient you are responsible for paying the $203.00 annual deductible and the 20% co-insurance or 20% of the amount approved by Medicare. Medicare will not pay for Physical Therapy if a patient is currently receiving services from a Home Health Care Agency. Please advise us if you are receiving Home Health services so we can determine if the agency will pay for outpatient Physical Therapy. You are financially responsible for any amount that Medicare denies due to Home Health coverage.

LITIGATION CASES: We find it a financial burden to treat patients on a contingency basis. Therefore, when legal cases are pending settlement, we ask that the full charge be paid at the time treatment is rendered with the patient recouping expenses upon settlement.

I understand that I am personally liable for all debts incurred to this office, and responsible for all payments not covered by the insurance company.

Signature Date

CANCELLATION/NO SHOW POLICY

If you are unable to keep your appointment, please call as soon as possible to give us the opportunity to offer the appointment to another patient. Failure to cancel appointments with more than 24 hours notice will result in a $45.00 charge. Unexcused absences/no shows will be charged $45.00 per occurrence. One no show will result in discontinuation of services as will repeat cancellations made less than 24 hours prior to scheduled appointment.

Thank you for taking the time to read this policy statement. We hope it answers your questions regarding payment of fees. If you have any questions, please ask the receptionist for clarification.

I have read and understand my financial responsibility for any physical therapy treatment received.

Signature Date