Preferred Physical Therapy Associates, Inc.

Welcome to Preferred Physical Therapy Associates, Inc.

Our comprehensive rehabilitation facility offers the advantage of Physical, Occupational and Speech Therapy under one roof.

Our experienced therapists offer you the opportunity to benefit from varied approaches and techniques.

Our Total Therapy Solution ensures that you are evaluated by the appropriate discipline for your optimal care.

- Please try to arrive on time for your appointment
- Always check in at the front and take care of co-pay & membership before therapy
- Have a seat in our waiting area until your therapist comes for you
- Family must wait in the reception area due to HIPAA restrictions
- Please make sure you have enough appointments for at least the next 4 weeks
- At least 24-hour cancellation notice is required to avoid a late fee
- Our Therapists work in teams and you may be treated by more than one of our experienced therapists during the course of your treatment in order to accommodate your schedule

We appreciate this opportunity to provide your therapy. We know that you will be very pleased with our many specialist therapists and state-of-the-art facility. If you have been satisfied with your therapy, **please tell your friends and Doctor.**

Your suggestions and comments are always welcome.

Welcome to our clinic, where we treat our patients like family

Trevor Meyerowitz
Owner

3994 W Hillsboro Blvd, Deerfield Beach, FL, 33442 Tel: 954-360-7779 Fax: 561-395-6995

Preferred Physical Therapy Associates, Inc.

Annual Membership Program

Patient Name: _____ Date: _____

Due to the ever-changing world of healthcare in general, and physical therapy in particular, Preferred Physical Therapy Associates has decided to establish an Annual Membership Program, **to maintain the high quality of care we have provided for almost 2 decades**. We have been providing many services for years **without being reimbursed** by insurance companies as they do not pay for all services (e.g. Cold Laser Therapy, Shockwave Therapy, Cupping Therapy etc.). We therefore established the Annual Membership Program, and believe this program will help us establish and maintain our relationships with our patients, build trust with our patients, and allow us to offer enhanced services to the Members.

All Patients of Preferred Physical Therapy Associates are eligible to become Annual Members of the Program for a small fee. In fact, we hope that **all** our patients become Members, although we do offer the option of opting out of Membership. We believe this program will serve the best interests of both the Practice and our Member patients.

1.Benefits of the Preferred Membership Program:

The following Services are **INCLUDED IN THE MEMBERSHIP PROGRAM, AT NO ADDITIONAL CHARGE** (These Services are not reimbursed by insurance):

✔ Cold Laser Therapy (a $30 value with each treatment)

✔ Shockwave Therapy (a $30 value with each treatment)

✔ Cupping Therapy (a $30 value with each treatment)

✔ Paraffin Therapy (a $30 value with each treatment)

✔ Custom Orthotics (a $50 discount will be applied)

✔ Electrodes for Electrical Stimulation (a $15 value)

✔ Disbursement of a Home Exercise Elastic Band (a $15 value)

✔ Kinesio-Taping – each application (a $30 value each treatment)

✔ Supplies related to TMJ treatment (a $20 value)

✔ NSAID Topical Gel used with/without Ultrasound Gel for phonephoresis (a $15 value) ✔ Access to PT Wired Exercise App with 2 updates to exercise prescription (a $30 value) ✔ Use and Analysis of Vertigo Goggles in all tested positions (a $75 value each treatment) ✔ Complimentary 30 minute session with a therapist when signing up for 3 or more private pay sessions ($80 value) ***Complimentary Membership Gift*** at the completion of initial plan of care.

Annual Membership is not required in order to receive the above-mentioned services at Preferred Physical Therapy Associates. However, Non-Members that utilize the above services per treatment will have to pay for them accordingly (only 1 item charge per treatment).

2. **Membership Fees**:

The annual membership fee of **$95** is due upon signing this Agreement and is non-refundable. All the above services for 1 year are included.

3. **Opting Out**:

Membership is not required in order to receive services at Preferred Physical Therapy Associates, and the Listed Services are still available. However, Non-Members will be charged the rate of the highest list charge in paragraph 1 per treatment (only 1 charge will be applied per treatment) when any of the Listed Services are utilized. That fee is subject to change, and payment for the Services is due at the time service is rendered.

4. **Term and Termination**:

This Agreement is valid for one year from the date of signing. It may be terminated by either party with 30 days' written notice. However, the Membership Fee is non-refundable.

5. **Entire Agreement**:

This Agreement constitutes the entire understanding between the parties and supersedes all prior agreements, whether oral or written, concerning the subject matter herein.

By signing below, the above-named patient agrees to the terms of this Agreement, or elects to opt-out.

x_____ Check for membership ◯ Check if you elect to opt out ◯

Patient Signature

Preferred Physical Therapy Associates, Inc.

Welcome to our clinic.

Please take a few minutes to answer the following questions so we may better assist you.

Name: (First MI Last) _____ _____ _____

Address: _____City: _____ State: _____

Zip:_____ Date of Birth: _____/_____/_____ Social Security #: _____/_____/_____

Email _____@_____

Preferred method of contact for appointment reminders: ____ Email ___Text Message ___ Phone Call

Telephone: _____ Cell Phone: _____

In case of an emergency, who should we contact? _____

Telephone: _____ Relationship: _____

Who may we thank for this referral: _____

Primary Insurance: _____ Policy Number: _____

Policy Holder: _____

Secondary Insurance: _____ Policy Number: _____

Policy Holder: _____

Are you involved in litigation? ___YES ___NO If yes, please provide information: _____

_____

Preferred Physical Therapy Associates, Inc.

Patient's Name: _____ DOB: ___/___/___

Please list all current medications:

Medication	Reasons for Medication

Preferred Physical Therapy Associates, Inc.

CHIEF COMPLAINTS:

Please list part(s) of your body that you are experiencing difficulties with? _____

Do you have or have ever had any of the following?

CONDITION	YES	NO	CONDITION	YES	NO
Asthma, Bronchitis, Emphysema			Severe or Frequent Headaches		
Shortness of Breath			Vision or Hearing Problems		
Coronary/Heart Disease			Numbness or Tingling		
Do you have a Pacemaker			Dizziness or Fainting		
High Blood Pressure			Balance problems		
Heart attack or Chest pain			Radiation of symptoms into the arms/legs		
Recent Hospitalization			Weakness		
Parkinson's Disease			Weight/Energy Loss		
Stroke/TIA			Hernia		
Blood Clot/ Emboli			Varicose Veins		
Epilepsy/Seizures			Allergies		
Thyroid trouble/Goiter			Any pins or Metal implants		
Anemia			Joint Replacements		
Infectious Disease			Neck Injury/Surgery		
Diabetes			Shoulder Injury/Surgery		
Kidney Problems			Elbow Injury/Surgery		
Cancer or Chemotherapy/Radiation			Back Injury/Surgery		
Arthritis/Swollen Joints			Knee Injury/Surgery		
Osteoporosis			Leg/Ankle/FootInjury/Surgery		
Gout			Do You Smoke?		
Sleeping Problems/Difficulties			Are you Pregnant?		
Emotional/Psychological Problems			Are you sensitive to Heat/Ice?		
Bowel or Bladder Problems			Other		

Preferred Physical Therapy
Associates, Inc.

CONSENT FOR TREATMENT
AUTHORIZATION OF PAYMENT

I, hereby authorize the therapy treatment by Preferred Physical Therapy Associates, Inc. for myself, my spouse or any minor child. I, hereby authorize Preferred Physical Therapy Associates, Inc. to provide medical care, treatment and all diagnostic examinations and any procedures required in the Plan of Care during the visits and appointments. I indemnify Preferred Physical Therapy Associates, Inc. from any injuries that may arise during the course of treatment, including Theragun and use of treadmill

I hereby authorize Preferred Physical Therapy Associates, Inc., their agents or any representative or billing company to request or receive any medical information needed in the care or treatment or billing of same needed. I further authorize the parties to release any medical or billing information required to any party needed. I hereby release all the above parties from any liabilities, responsibilities, damages or claims that might arise from the release of any information.

I understand that all therapy services will be billed directly to Medicare or other primary insurance company and any secondary insurance provider by a third-party billing company**. I certify that the information given by me in applying for payment is correct. If there are any changes to insurance, I will notify the front desk immediately, failure to do so could result in me being responsible for all services.** I authorize the release of all records on request and those payments of authorized benefits are made on my behalf. I hereby direct all payments be made directly to Preferred Physical Therapy Associates, Inc.

MEDICARE PATIENT'S ONLY:

Medicare requires that we certify that the reason you are receiving therapy is unrelated to any open or prior auto/ liability accident/case. By signing below, you are acknowledging that the treatment you are seeking at our facility, Preferred Physical Therapy, is unrelated to any injuries sustained in an open or prior auto or liability case and you are NOT currently receiving Home Health Services. If this is the case, please notify the front office.

Medicare has imposed therapy services caps for physical & speech therapy combined and occupational therapy. We want to assure you, that if services are provided in excess of the therapy cap; we have deemed these treatments are medically necessary and YOU ARE NOT RESPONSIBLE FOR ANY PAYMENTS SHOULD MEDICARE DECIDE NOT TO REIMBURSE US.

I understand that this billing procedure is done as a courtesy and in the event that the payment is received by me, I will immediately forward the same or in the event that either insurance providers fail to pay the claims, I will be responsible for immediate payment in full. I understand that I will be responsible for any deductibles, coinsurance charges not covered by my carriers.

Patient's Signature: _____ **Date:**_____

Print Name: _____

Preferred Physical Therapy
Associates, Inc.

NOTICE OF PRIVACY PRACTICES

This Notice describes how medical information about you may be used and disclosed and how you get access to this information. Please review carefully.

We care about our patients' privacy and strive to protect the confidentiality of your medical information in our practice. New Federal legislation and all additional final rules require that we issue this official notice of our privacy practices. HIPAA is short for the **Health Insurance Portability Act of 1996**. This law regulates patient privacy, information access, fraud prevention, group health plan requirements, and billing simplification throughout the healthcare industry. HIPAA protects the privacy of your individual health information. **It also gives you additional rights to access change or restrict the use of your health information. It also gives you additional rights to access change or restrict the use of your health information. It allows you full access to your records whether written or electronic.**

We use or disclose your health information to carry out treatment, co-ordinate and provide your care with your physician, health care professionals outside this office or your family that are all involved in your care. **Your records cannot be used for marketing purposes. We will only contact you or your family by telephone for the sole purpose of confirming your appointments**. We use or disclose your health information to obtain payment for your treatment as required by your insurance company or Medicare. **If either your insurance company or Medicare is not paying for any treatments, your records will not be shared with them.** We use or disclose your health information to improve the quality of our services, plan better ways of treatment or evaluating our staff performance. **The only other permitted disclosure of your health information would be to the Secretary of Health and Human Services to investigate or determine compliance, any Federal, state or local law requirements or a Workers' Compensation Claim.**

We will only disclose any of your information, amend your information, amend to whom we share your information or provide you with a copy if requested by you in writing to the **Office Administrator**. You may file any complaint in writing to the Secretary of Health and Human Services, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201.

I HAVE INDICATED ALL MEDICAL AND OTHER INFORMATION TO BETTER ASSIST PREFERRED PHYSICAL THERAPY ASSOCIATES, INC. IN MY CARE AND TREATMENT AND TO PREVENT ANY HARM TO ME DURING MY THERAPY. I HAVE READ ALL THE ABOVE AND MAY REQUEST A COPY AT ANY TIME.

Please list who we may discuss your information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient's Signature: _____ Date: _____

Print Name: _____

Preferred Physical Therapy
Associates, Inc.

CANCELLATION POLICY

Preferred Physical Therapy strives to provide excellent care for all of its patients. We have several therapists on staff who have expertise in different areas of the body. This enables our facility to treat a large range of medical issues. We have been providing therapy in South Florida for over 11 years and have helped thousands of patients. Each and every person who is treated at our office becomes our number one priority and our patients appreciate the dedication of the entire staff.

In order for Preferred Physical Therapy to continue its ability to provide patients with excellent treatment, it is also imperative that you understand that you must be present for your appointments. If you do not come to your visits, then your problem is not going to improve. In addition, our therapist are scheduled according to the time that has been reserved for each client. If a patient does not show for their assigned appointment or cancels a couple hours prior to their scheduled visit, then the therapists time is wasted, and a patient who would have come in for that appointment loses the opportunity for receiving care. Preferred Physical Therapy wants to ensure that time is available for the people who want care and need therapy, and who come to their visits**. Unless it is a valid emergency, patients who are no shows, cancel the day of their appointment and/or give less than 24 hours notice, will incur a fee of $50**. This policy helps to ensure that all patients can continue to receive the care they deserve in a timely manner.

I have read the policy letter.

Signature: _____ Date:_____

Print: _____

A. Notifier: Preferred Physical Therapy Associates, Inc

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D. Services in the Outpatient setting** below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care providerhave good reason to think you need. We expect Medicare may not pay forthe **D. service below**.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Physical/Occupational Therapy in the Outpatient setting.	Other services being rendered in the home covered under Medicare.	$150 per Treatment

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finishreading.
- Choose an option below about whether to receive the **D. Services** listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box foryou.

✔ **OPTION 1.** I want the **D. Services** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

OPTION 2. I want the **D. Services** listed above, but do not bill Medicare. You may a ask o be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed. **OPTION 3.** I don't want the **D. Services** listed above. I understand with this choice I a am **not** esponsible for payment, and I cannot appeal to see if Medicare wouldpay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486- 2048).Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

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