S.T.A.R.
PHYSICAL THERAPY P.L.L.C.

790 Ayrault Road • Fairport, New York 14450
(585) 425-1018 FAX (585) 425-8955
http://www.star-physicaltherapy.com

Name ____ **DOB:** ___/_______/_______
First *MI* *Last*

Address ____
Street *City* *Zip Code*

Home Phone________________________**Cell Phone**__________________________**Email**______________________________

Appointment reminders *(circle one)* Text / Email **Cell Phone Provider** *(needed for text reminder)*________________________

In case of emergency, please notify____________________________________**Relationship**________________________________

Phone Number:_______________________

How did you hear about us? *(Please select best answer)*

- ☐ Physician recommended _______________
- ☐ From a list my physician gave me
- ☐ Greater Rochester Chiropractic
- ☐ Friend/relative _______________________
- ☐ Past patient returning for a new problem
- ☐ Anchor Fitness member
- ☐ Saw building/sign
- ☐ Website (www.star-physicaltherapy.com)
- ☐ General internet search
- ☐ Other _______________________

HIPAA Notice of Privacy Practice

We at STAR Physical Therapy respect our patient's right to privacy at all times. As required by the **Health Insurance Portability and Accountability ACT (HIPAA)** we adhere to the standard set forth in the **Notice of Privacy Practice** provided with your paperwork. Copies are available upon request. This document states that we reserve the right to contact you by mail or phone. We may leave a message regarding appointment confirmation, scheduling payment for services and treatment issues. By signing this agreement, you are granting us permission to do so. I hereby acknowledge that I have received a copy of STAR Physical Therapy's Notice of Practice Practices.

Patient or Guardian Signature ____________________________________ **Date** ________/______/______

Optional: Designation of Personal Representative

Name(s) ____**Relationship** __________________________

I acknowledge and agree that STAR Physical Therapy may disclose my protected health information to my personal representative and that my personal representative had the authority to authorize STAR Physical Therapy to use and disclose my protected health information, this includes scheduling and changing appointments.

Signature ____**Date** ________/______/______

S.T.A.R.
PHYSICAL THERAPY P.L.L.C.
790 Ayrault Road • Fairport, New York 14450
(585) 425-1018 FAX (585) 425-8955
http://www.star-physicaltherapy.com

Financial Policy

Payment is expected at the time services are rendered unless specific credit arrangements have been made in advance.

Patients with Medicare: Claims will be submitted to Medicare on the patient's behalf. Patients are responsible for an annual deductible and a 20% co-insurance. A claim will be sent to your supplemental insurance when information is provided by the patient. If a balance remains after insurance(s) have reviewed and made any payments on claims, you will then become responsible for that final payment.

Patients with Insurance: Patients are responsible for deductibles, co-payment, non-covered service, coinsurance and items considered "not medically necessary" by the insurance company. A claim will be submitted to the insurance company when our office is provided with the necessary billing information. Any remaining balance is due from the patient within 30 days of receipt of a statement. Our office will verify your insurance benefits prior to your first appointment as a courtesy, however it is the patient's responsibility to know their outpatient physical therapy coverage.

Patients with high deductible insurance: Health care providers are not reimbursed by insurance for services rendered before your deductible has been met. The fee for physical therapy services are set by your insurance company. We are unable to discount fees set by your insurance company. Patients with a deductible that has not been met will be responsible for a payment of $65 at the time of service.

Copay(s) are due at the time services are provided

Visits per calendar year: Most insurance plans have a set limit on the number of visits allowed per calendar year. If you exceed that visit number you will be responsible for charges for services.

Have you had physical therapy at another facility this calendar year? Yes No

If yes, how many visits did you complete? _________

Home Health Care: If you are currently receiving home health care, check with the insurance carrier to see if physical therapy treatment will be covered in addition to home health care. Any payment due for services provided while receiving home health care will be the patient's responsibility.

I assign STAR Physical Therapy all rights, privileges and remedies to payment for services rendered with which I am entitled. I have read and fully understand the above statements and acknowledge my responsibility to STAR Physical Therapy for all charges incurred.

Patient/Guardian Signature ______________________________ **Date**_____/_____/_____

Appointment Cancellation and No Show Policy

We are committed to providing you, our valued patients, with excellent quality and conveniently timed physical therapy services. We reserve time in our schedule specifically for you and we ask for your cooperation by making every effort to keep your scheduled appointments. **We ask that you provide at least 24 hours' notice for an appointment cancellation**. Occasionally, emergencies arise that make it impossible to keep scheduled appointments specifically, sickness, transportation and family emergencies. Cancellations without 24 hours' notice are acceptable under these conditions for **one time**. Cancellations due to inclement weather and/or hazardous driving conditions, extreme illness or a death in the family are always acceptable. In consideration of our other patients and our staff, please call as soon as possible if you are unable to keep a scheduled appointment. **Late cancellations or missed appointments will be charged a $25 missed appointment fee per instance.**

Patient/Guardian Signature ______________________________ **Date**_____/_____/_____