Financial Agreement
Balistreri & Associates Physical Therapy

We would like to take a moment to welcome you to our office and assure you that you will receive the very best care available for your condition. In order to familiarize you with the financial policy of this office, we would like to explain how your medical bills will be handled.

Insurance Coverage

Most insurance policies cover physical therapy, but this office makes no representation that yours does. Insurance policies can differ greatly in terms of deductible and percentage of coverage for physical therapy. Because of the variance from one insurance policy to another, we require that you, the patient, are personally responsible for verifying benefits with your insurance company and for payment deductibles, as well as any unpaid balances in this office. We will bill your insurance company(ies) in a timely manner. Your co-payment and/or co-insurance are required prior to each treatment. Any over payments will be refunded to you. An interest charge of 1 1/2 % per month may be applied to your past due balance.

Assignment of Benefits

Attached is an “Assignment of Benefits” form that we would like you to sign. This form instructs your insurance company to send their payments directly to this office. Please sign all copies of this form. If your insurance carrier sends you payment for services incurred in this office, you shall send or bring the full payment to our office immediately upon receipt.

Rescheduling / Canceling Appointments

If it is necessary for you to re-schedule an appointment, please call at least 24 hours in advance. If you are a no-show twice for an appointment we will charge you a $25 service fee. This would not be covered by insurance and a bill will be sent to you directly. After a third time no-show, you will be billed an additional $25 service fee and discharged back to your referring physician with an explanation.

Voluntary Termination of Care

If you suspend or terminate your care at any time, your portion of all charges for professional services is immediately due and payable to this office. All services rendered by this office are billed to your insurance company and the balances will be charged directly to you, and you ultimately will be personally responsible for payment, regardless of your insurance coverage.

Attention Medicare Patients

We are a certified provider under Medicare Part B. Medicare has placed a financial cap on physical therapy benefits for a limitation of $1810.00 for outpatient physical therapy benefits. Medicare has a deductible of $135.00 and pays 80% of approved services. Please inform us if you have secondary coverage. If you have had physical therapy at another facility this calendar year, please advise us on your first visit.

Previous Patients

If you have received physical therapy from our office at a previous date and have a balance from a previous account, you will be required to pay no less than 50% of the balance and arrange a firm payment plan for the remaining balance prior to initiating a new account.

We hope that this answers any questions you might have concerning the financial policies of this office. Once again, we welcome you to our office and will be glad to answer any further questions you might have.

I have read and agree to the above

________________________________ Patient’s Signature

________________________________ Date

CO-PAY and CO-INS is collected at each appointment.

CO-INS is an estimated amount calculated by our billing department according to YOUR insurance benefits.

Patients may receive a monthly bill for additional CO-INS due if we have under-estimated the amount after YOUR insurance begins paying your claims. We will adjust your payment amount if necessary at that time.

This is a BALISTRERI and ASSOCIATES business policy done to relieve the possible financial burden to our patients of receiving large monthly statements. YOUR insurance deducts the CO-INS you owe from their payments to BALISTRERI and ASSOCIATES for YOUR treatment. Since physical therapy is an on-going treatment, these un-paid portions due from patients can add up quickly.

Please understand that this is a SERVICE we provide to you. Many facilities do not do this and simply send a large monthly bill for CO-INS due in full in 30 days. We want you to be able to concentrate on your treatment and getting well quickly, not how you will pay your bill.

THANK YOU for your anticipated cooperation.

I have read the above (Sign here) ____________________________

To Our Patients Regarding Cancellations and No-Shows

The following are our policies regarding cancellations and no-shows. We take this subject seriously at this clinic, because it can make a difference between whether you succeed in your treatment or not. Your referring doctor has prescribed a set frequency of treatment visits and showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow our therapist's instructions and we will be able to help you achieve your goals in treatment.

- If it is necessary for you to reschedule an appointment, please call at least 24 hours in advance. When you call, please be prepared to reschedule that appointment to ensure you get in the full prescribed number of treatments that week.

- Please be on time for all of your scheduled appointments. If you arrive 10 minutes after your treatment time, you may not be seen for your appointment. This appointment may be counted as a cancellation without prior notice.

- There is a $25 service fee for 2 no-show or cancellation without prior notice. This charge will not be covered by insurance and a bill will be sent to you directly. If you no-show or cancel without proper notice a third time, you will be billed a $25 service fee and discharged back to your referring physician with an explanation.

- For Worker's Compensation and Personal Injury patients, documentation of any missed appointments is forwarded to your Case Manager and Referring Physician and this could jeopardize your claim.

- You may need to see a therapist other than the one who normally treats you if you do reschedule an appointment. All of our therapists are experienced professionals, and they will study your patient chart, so you will be in good hands. You will return to your original therapist in the next regularly scheduled visit.

- Please understand that your pain will probably increase and decrease as your course of treatment progresses. Neither of these conditions is legitimate as a reason not to come in: a) if you're in pain, come in and we can help to alleviate it, b) if your pain has decreased, now is the time that we can do more correction of the underlying causes of your problem and educate you to prevent further injury.

When you don't show as scheduled, three people are hurt: 1) You, because you don't get the treatment you need as prescribed by the doctor, 2) the therapist, who now has a space in their schedule since the time was reserved for you personally, and 3) another patient who could have been scheduled for treatment if you had given proper notice.

Please co-operate with us in this regard. We're looking forward to working with you to achieve your best possible outcome!

______________________________ ______________________

Patient Signature Date

Balistreri & Associates Physical Therapy

•Physical Therapy• Aquatic Therapy• FCE

Who referred you to BAPT?____

Was this the first time you heard of BAPT? ☐Y ☐ N

If No, WHERE?____

PATIENT INFORMATION

Patient Name:____
Last First Middle

Date of Birth:______________________**SSN:**______________________

Address:____
Street

____
City State Zip

Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Minor
☐ Widowed ☐ Separated ☐ Divorced

Patient Employer/School:____

Employer/School Address:____

______________________ ____

Occupation: ______________________ **Business Phone:** ______________________

Spouse's Name **(or responsible party):** ______________________ **SSN:** ______________

Employer: ____

Employer/School Address: ____

______________________ ____

Occupation: ______________________ **Business Phone:** ______________________

____

ACCIDENT INFORMATION

Is this condition due to an accident? ☐ Yes ☐ No

Date of Injury:____________**Type of accident:** ☐ **Auto** ☐ **Work** ☐ **Home** ☐ **Other**

Have you made a report of your accident? ☐ **Yes** ☐ **No**

Attorney Name:____

Phone:____

CONTACT INFORMATION

Home Phone: (____)______________________________

Cell Phone: (____)______________________________

Work Phone: (____)______________________________

E-Mail Address:______________________________

Best time and place to reach you:____________________

IN CASE OF EMERGENCY CONTACT:

Name______________________________

Relationship: ______________________________

Home Phone: ( )______________________________

Cell Phone: (____)______________________________

Work Phone: (____)______________________________

REFERRING PHYSICIAN

Name:______________________________

Phone:______________________________

Fax: ______________________________

Address:______________________________

PRIMARY CARE PHYSICIAN

Name:______________________________

Phone:______________________________

Fax: ______________________________

Address:______________________________

PATIENT CONDITION

Reason for Visit:____

When did your symptoms appear?____

Is this condition getting progressively worse? ☐ **Yes** ☐ **No** ☐ **Unknown**

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)____________________

Type of Pain: ☐ **Sharp** ☐ **Dull** ☐ **Throbbing** ☐ **Numbness** ☐ **Aching** ☐ **Shooting**
☐ **Burning** ☐ **Tingling** ☐ **Cramps** ☐ **Stiffness** ☐ **Swelling** ☐ **Other**

How often do you have this pain?____

Is it constant or does it come and go?____

Does it interfere with your ☐ **Work** ☐ **Sleep** ☐ **Daily Routine** ☐ **Recreation**

Activities or movements that are painful to perform : ☐ **Sitting** ☐ **Standing** ☐ **Walking** ☐ **Bending** ☐ **Lying Down**

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Services ☐ None ☐ Other ____________________

Name and address of other doctors who have treated you for your condition ____________________

____

Date of last: Physical Exam ________ Spinal X-Ray ________ Blood Test ________

Spinal Exam ________ Chest X-Ray ________ Urine Test ________

Dental X-Ray ________ MRI, CT-Scan, Bone Scan ________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition			Condition			Condition			Condition		
AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Unintended Weight Loss	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No	Other ________		
Cataracts	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Rheumatoid Arthritis	☐ Yes	☐ No	________		
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No	________		
Chicken Pox	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No	________		
Circulatory Problems	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Seizures	☐ Yes	☐ No	________		
			Metal Implants	☐ Yes	☐ No	Sensory Impairment	☐ Yes	☐ No	________		
			Migraines	☐ Yes	☐ No				________		

Exercise
☐ None
☐ Moderate
☐ Daily
☐ Heavy

Work Activity
☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

Habits
☐ Smoking Packets/Day ________
☐ Alcohol Drinks/Week ________
☐ Coffee/Caffeine Drinks Cups/Day ________
☐ High Stress Level Reason ________

Are you pregnant? ☐ Yes ☐ No Due Date ________

Injuries/Surgeries you have had	Description	Date
Falls	________	________
Head Injuries	________	________
Broken Bones	________	________
Dislocations	________	________
Surgeries	________	________

Medications	Allergies	Vitamins/Herbs/Minerals
________	________	________
________	________	________
________	________	________
________	________	________
________	________	________
________	________	________

Balistreri & Associates Physical Therapy

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used in the below circumstances.

I understand and give authorization to Balistreri & Associates Physical Therapy to make telephone calls to my home about my health related information and appointment reminders. A message may be left on my answering machine / voice mail,

I understand that letters may be sent to my primary physician and other healthcare providers (i.e. chiropractor, dentist, massage therapist, OBGYN, surgeon, acupuncturist, other medical specialist) that I see for medical care informing him/her that I am currently having therapy. If he/she requests updates on my progress, I am giving authorization to Balistreri & Associates Physical Therapy to send him/her copies of my progress reports that are also being sent to the referring physician. Please list below any EXCEPTIONS for providers that you **do not** authorize us to contact: Please list:

____

____

____

I hereby give my permission for authorized personnel of Balistreri & Associates to perform all necessary procedures and treatments outlined in the plan of treatment.

I hereby authorize a representative of Balistreri & Associates Physical Therapy to be permitted to obtain and review copies of all hospital, medical, vocational, and other related records and to discuss pertinent information with professionals involved in my case.

EXCEPTIONS: (Please list) ____

In specific instances I also authorize Balistreri & Associates Physical Therapy to share information regarding my rehabilitation to/from my employer. I understand that the information shared will be used to assist in tailoring my rehabilitation program to my specific job tasks. If applicable, name of employer/contact information: ___________________________________

This consent is to remain in effect until otherwise revoked by me in writing. I agree that a photocopy of this authorization be accepted if necessary.

I, ____, have read and understand the above as
(printed name)
well as the privacy notice provided to me by Balistreri & Associates Physical Therapy.

_________________________ ____
Date Signature

Assignment and Instruction for Direct Payment to Health Provider

Patient: ____

Address: ____

City: _________________________ State:__________________ Zip: _________________

Insurance Company: ____

Claim or Group #: ____

I hereby instruct the above named Insurance Company to pay directly to:

Balistreri & Associates Physical Therapy
6926-39th Avenue
Kenosha, WI 53142

For professional or medical expense allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED EFFECTIVE AND VALID AS THE ORIGINAL

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, attorney, or state appeal board for the purpose of securing payment under this policy or insurance.

Signature of Policy Holder: ____

Date: ____

Signature of Claimant, if other that Policy Holder: ___________________________________

Patient's Name: _____________________________ Medicare # (HICN): ____________________