

Date \_\_\_\_\_ Name you would like to be called \_\_\_\_\_

NAME \_\_\_\_\_ DOB \_\_\_\_\_

Address \_\_\_\_\_ SS# \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Email: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Are you an active member in the military or naval services of the United States? Y N

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home# \_\_\_\_\_ Work# \_\_\_\_\_ Cell# \_\_\_\_\_

Date of Onset \_\_\_\_\_ How: \_\_\_\_\_

Due to (circle one): Work Car Accident Other: \_\_\_\_\_

Is an attorney involved with this case? No / Yes Attorney's Name: \_\_\_\_\_

Major Diagnosis / Complaint: \_\_\_\_\_

Doctor(s) seen for this: \_\_\_\_\_

Tests Performed (circle all that apply) X-rays MRI CT Scan EMG Other: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Date of last Exam: \_\_\_\_\_

Medical History:

<input type="checkbox"/>	Currently Pregnant	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Cancer: _____
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	Arthritis: _____
<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Surgery: _____
<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Allergies: _____
<input type="checkbox"/>	Angina	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	Other: _____

Medications you are taking: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**INSURANCE:** This is a contract between you and your insurance company. There are many different insurance companies with various benefit plans and requirements. APTC will assist you in obtaining your benefit quote however, your insurance carrier WILL NOT guarantee the accuracy of this information. For specific information about your plan coverage and limitations please refer to your insurance handbook, your insurance web site or call the 800 number on your card. Depending on your plan, some APTC providers may be in-network while others may be out-of-network.

**CHANGES IN INSURANCE COVERAGE:** It is your responsibility to notify this office of any and all changes in your insurance coverage. Failure to do so may result in a denial of coverage from your insurance company, thus making you financially responsible for payment. Also, if your policy terminates for any reason, you will be financially responsible for payment.

**NOTICE OF PRIVACY PRACTICES:** I understand that I have certain rights regarding my protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I acknowledge that I may request a copy of Advanced Physical Therapy Center of Stamford LLC's Privacy Policy at any time.

**ASSIGNMENT & RELEASE:** I authorize direct payment of medical benefits to Advanced Physical Therapy Center of Stamford, LLC, 1234 Summer Street, Stamford, CT 06905. I authorize Advanced Physical Therapy Center of Stamford, LLC, and Medical Management Solutions, LLC to appeal any decisions made by my insurance company on my behalf. I also authorize the therapist and Advanced Physical Therapy Center of Stamford, LLC to release all information necessary to secure the payments of benefits. I authorize this signature on all insurance submissions.

**RELEASE OF MEDICAL INFORMATION:** I \_\_\_\_\_ hereby authorize Advanced Physical Therapy Center of Stamford, LLC to release and obtain my medical records regarding my condition which includes, but not limited to history, findings, diagnostic tests, diagnosis, prognosis, casual relationship, office notes or pertinent data. This also authorizes telephonically, voicemail, facsimile, e-mail or electronic data release of current medical and billing pertaining to my condition. I understand and agree that a photocopy or facsimile of this authorization may be accepted to release or obtain information as though it were an original.

Referring Physician \_\_\_\_\_ initials \_\_\_\_\_

Primary Care Physician \_\_\_\_\_ initials \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ initials \_\_\_\_\_

Employer (WC only) \_\_\_\_\_ initials \_\_\_\_\_

Attorney \_\_\_\_\_ initials \_\_\_\_\_

\_\_\_\_\_ initials \_\_\_\_\_

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian Name & Relationship

\_\_\_\_\_  
Guardian Signature

\_\_\_\_\_  
Date

**FINANCIAL RESPONSIBILITY:** You are ultimately responsible for payment of services.

**CO-PAYMENTS, CO-INSURANCE and DEDUCTIBLES** are due on the day of service.

**NO-FAULT:** Some patients have a medical payment rider on their auto insurance policy. Please provide this information if you would like APTC to bill your auto carrier. If you do not have a medical payment rider, you may be required to get a “no med-pay” letter from your auto carrier so we can bill your private insurance carrier. In addition, your private insurer may have procedures we must follow, so to avoid a denial of coverage we may need for you to disclose your medical payment balance. You will still be required to pay your co-payments, co-insurance and deductibles as we do not accept attorney letters of protection.

**WORKER’S COMPENSATION:** It is your responsibility to notify this office immediately of any change in your workers’ compensation status. If you claims is contested and or denied, you will be responsible for payment.

**MEDICARE:** You are responsible for a yearly deductible. We will bill Medicare and your secondary insurance carrier if you have one. You are responsible for any remaining balance up to the Medicare allowable fee.

**INSURANCE PAYMENTS:** In the event that your insurance company issues payment directly to you, please endorse the check to “**APTC of Stamford LLC**” and send it with the Explanation of Benefits to this office immediately. Failure to do will result in you incurring the TOTAL billed amount in addition to legal action.

**ADDITIONAL CHARGES:**

A \$5.00 administrative fee may be added for billing of unpaid co-payments, co-insurance or deductibles.

A 1.0% monthly interest charge will be added to any unpaid balances after 30 days.

A \$20.00 fee will be added to all returned checks.

Attorney fees will be charged to resolve any outstanding balances.

**PAYMENT OPTIONS:** We accept CASH, CHECK, MASTERCARD, VISA, AMEX and DINERS CLUB. You must receive a receipt with EVERY cash payment.

**REFERRALS:** If your plan requires a “referral on file” from your primary care physician, it is your responsibility to obtain this prior to your appointment. If this is not obtained (or is not “on-file” with your insurance company) prior to your visit, you will be financially responsible for payment.

**BILLING:** We use an outside company to bill your insurance company and collect payments. If you have any questions regarding a bill, you can reach MMS at 914-366-6161.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian Name & Relationship

\_\_\_\_\_  
Guardian Signature

\_\_\_\_\_  
Date