Aging with Purpose LLC

Adult Initial Intake Form

Name of Patient: _____

GENDER: M F

DOB: ___/___/____

Social Security Number: _____

Referred By : _____

Date of accident / onset of injury/disease: _____

Explain, in your own words, why you are seeking therapy:

_____

_____

Patient Information

- Address: _____
- Telephone _____
- Emergency Contact #

Name _____ Relationship _____ Telephone _____

- Medications -Reason for Taking:

_____

_____

_____

- Durable Medical Equipment Currently Used (walker, cane, chair lift, etc) :

_____

_____

_____

- Primary Care Physician (name, telephone, address):

Name: _____

Telephone:_____

Address: _____

- Specialist* Care Physician (name, telephone, address):

Name: _____

Telephone:_____

Address: _____

- Specialist* Care Physician (name, telephone, address):

Name: _____

Telephone:_____

Address: _____

***Specialist includes Neurology, Orthopedic, Cardiac, Pain Management, Ophthalmologist, etc.**

IF MANAGED CARE CASE: Nurse to Contact After First Visit:

Name: _____ Phone:_____

BILLING INFO:

Name of **Policy Holder** (subscriber) if different than Patient (dependent):

_____

NAME OF CARRIER: _____

☐ PRIVATE INSURANCE (Name of Plan _____)

ID#_____ Group # _____ Effective _____ Expired _____

☐ Medicare Part B (Red, White, and Blue Card)
— IF you do NOT have a Medicare Advantage Plan

ID#_____ Effective _____ Expired _____

☐ Medicaid
ID#_____ Effective _____ Expired _____

☐ Private Pay

——————————Office Use Only ——————————-

- Assignment of Benefits Required? (Close to or exceeding benefit)

_____

- Terms/ Limits of Policy (Restrictions of policy / Visit maximum)

_____

- Authorization for Treatment Required

YES NO

- Claim / Group or Authorization #

_____

I certify all of the above information is true and accurate, to the best of my knowledge and abilities:

_____ _____

Signature of Patient or Authorized Representative Date

Aging with Purpose LLC

Assignment of Benefit Form

Patient's Name: _____

Date: _____

Insurance

I _____ understand that my insurance company will be sent an itemized bill for each session in accordance to reasonable and customary charges. I agree to assign benefits directly to Aging with Purpose LLC for all therapy services rendered. I also agree to remit any monies sent to me in error from my insurance company for services rendered to Aging with Purpose. I agree to pay for all services rendered should my insurance company deny payment for services rendered, and will be responsible for any deductible, co-insurance or co-payment, to be paid at the time of my visit.

Private Pay or Out of Network Benefits

For patients who pay privately or have out-of-network benefits, payments are due at the time of your visit. The fee for service for an initial evaluation is $160.00/hr. The fee for service for all follow-up visits is $120.00/hr. If requested, Aging with Purpose will assist you in submitting claims to your insurance company.

CANCELLATION and DISCONTINUANCE FROM SERVICES POLICY

This office requires 24 hours notice for cancellations. Otherwise, you will be charged the full fee of the session. In addition, you will be charged the full fee for the session if you do not show for a confirmed appointment. Should you miss three consecutive visits it will be considered that you are not in adherence or compliance with your plan of care, and will be discharged from this office. Your primary physician will be notified and you will be given the names of three like professionals for your future use should you decide to begin therapy services again.

I have read and agreed to the above policies and procedure

Patient Signature_____

Date_____

Aging with Purpose LLC

Patient Notification of Billing/Cancellation Procedures

Charges for services that are provided by Aging with Purpose LLC are based upon the procedures that are deemed necessary by the therapist and physician to enable the patient to reach their goals. The patient is responsible for the payment of all fees regardless of whether the patient has insurance coverage for all or part of the bill. If the patient does have insurance that will pay for a portion or all of the service, Aging with Purpose will bill the insurance company with the understanding that the patient provides all the necessary information, including but not limited to, a claim number, insurance card and a signed insurance form.

FEES and EXPENSES

1. Initial Evaluation - The charge for this is calculated on an hourly rate; rates can be pro-rated should an evaluation last longer than one hour.

2. Time sensitive direct therapy services – These can include such services as therapeutic exercise, massage, traction, kinetic exercises and activities. Charges for these services are based on one to one treatment time and are billed in 15 minute increments.

3. Modalities – This can include but not be limited to ultrasound, hot packs, electric stimulation, cold packs etc. There are separate charges for these services which may be performed by the primary therapist and in some instances a therapy aide or assistant.

Fees are reviewed on an annual basis, and Aging with Purpose reserves the right to adjust the fees when it is deemed necessary. Thirty day advance written notification will be provided if any fee increase is instituted.

BILLING FOR SERVICES RENDERED

All bills for services rendered will be sent out to the insurance carrier within thirty days of the service performed. Any co-payment, co-insurance, or deductible is due at the time of service. For patients paying out of pocket, payment is expected at the time of service unless other arrangements have been made. All invoices unpaid after 45 days will be subject to the maximum interest penalty/finance charge allowed by law. Aging with purpose reserves the right to cancel treatment if payment for services is not received, and to use whatever means necessary including an attorney, small claims court, or collection agency in an attempt to secure payment

_____ _____

Signature of patient Date

Financial Policy

Patient's Name (Please Print) _____

DOB ____/____/_____

□Accept Assignment_____

□Not Accept Assignment _____

□Medicare

□Self-Pay

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies. Payment is due at the time of service unless arrangements have been made in advance. We accept Visa, MasterCard, American Express, Discover, debit cards, cash and checks. The patient is obligated to pay for late cancellation fee/no show fee/fee for arriving late/ non-sufficient funds fee, and these particular fees cannot be billed to any insurance companies.

Cancellation Fee (less than 24 hours) $20
No Show Fee $25
Non-Sufficient Funds Fee $15
Canceled/Stopped Check Fee $15
Late fee (for each 15 minutes) $5

****Not all insurance plans cover all services. In the event your insurance plan determines a service "not to be covered," you will be responsible for those charges. Please be aware that some insurance companies have a maximum number of visits that you are allowed; some companies also require prior-authorizations. It is the patients' responsibility to know their carrier's therapy benefits, check with their insurer if the prior-authorization is required and to follow up with our office if it was obtained & visits were approved.*

Accept Assignment Patients:

We have made prior arrangements with some insurance companies to accept an assignment of benefits. As a service to you, we will file your insurance claim if you assign the benefits to Aging with Purpose – in other words, you agree to have your insurance company pay us directly.

> "I agree to make immediate co-insurance and deductible payment upon receipt of services rendered. If Aging with Purpose doesn't get reimbursed from my insurance company within 30 days from date of service, I will be financially responsible for the full remaining balance. If my insurance issues me the checks because Aging with Purpose is an out-of-network provider, I am responsible to assign them to Aging with Purpose LLC. If my insurance company determines that my visits are (were) not medically necessary, I am responsible to pay the full fee for my treatments.

Not Accept Assignment Patients: If you are insured by a plan that we do not have prior arrangement with, we will prepare and send the claim for you in an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due in full at the time of service.

> I agree to make immediate payment upon receipt of services rendered. I understand that my insurance forms will be submitted electronically/mailed from Aging with Purpose so that I may get reimbursed. I also have the option of mailing out the insurance forms myself so that I may get reimbursed. It is also my responsibility to follow up on my reimbursements with my insurance company.

Private Patients: *Payment is expected at the time of service. Upon request, we will give you a paid bill to submit to your insurance company so that you can attempt to get reimbursed in part or in full. With your permission, we will cooperate fully with your insurance company if they request copies of treatment notes or other information related to the processing of your claim. Please note that we cannot make any representation that your insurance company will reimburse you in part or in full for our services, and payment to us in full is required regardless of the final determination of coverage by your carrier.*

IF ANY PAYMENTS ARE OVERDUE BY 60 DAYS, UNCOLLECTED FUNDS WILL BE SENT TO OUR COLLECTION AGENCY AND COLLECTION /PROCESSING/ATTORNEY/COURT FEES WILL BE ADDED. ALL INVOICES SHOULD BE DUE AND PAYABLE TO AGING WITH PURPOSE LLC WITHIN 30 CALENDAR DAYS. PATIENTS WILL BE RESPONSIBLE TO PAY 10 % LATE FEE OF A MONTHLY INVOICE AMOUNT.

I HAVE READ AND UNDERSTOOD AGING WITH PURPOSE'S FINANCIAL POLICY AND I AGREE TO BE BOUND BY ITS TERMS. I ALSO UNDERSTAND THAT SUCH TERMS MAY BE AMENDED BY THE PRACTICE FROM TIME TO TIME.

Patient /Guardian Signature _____ Date_____

Notice of Patient Privacy Practices

According to the Health Insurance Portability and Accountability Act, known as HIPAA, physical, occupational and speech therapists in private practices must incorporate the federal privacy standards to protect patient's medical records and other health information provided to health plans, doctors, hospitals and other health care providers. Please note that your personal health information may be used by Aging with Purpose for treatment, obtaining payment, during an audit, in emergencies, or when required by law. You will be asked for written authorization to use their personal medical information for any other reason than those listed above. You have the right to review their personal health information at any time, to request that inaccurate information be corrected, or to request a list of instances when the information has been disclosed for reasons other than treatment, payment or other administrative purposes. You have the right to restrict how the information is used and disclosed for treatment, payment and administrative operations. The requests for restrictions will be considered on a case-by-case basis. You have the right to address concerns and complaints about a potential violation of their health privacy to the US Department of Health and Human Services.

For further questions, you may contact the Compliance Officer,

Michelle Eliason
40 Gardenville Parkway W.
Suite 208
West Seneca, NY 14224
716-235-3013

Aging with Purpose LLC

Patient Information Consent Form

I have read and understand this practice's **Notice of Patient Information Practices**. I understand that the company may use, obtain, or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the company. I also understand that the Company will consider requests for restrictions on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in the Company's **Notice of Patient Information Practices**. In doing so, I hereby release Aging with Purpose LLC from any and all legal liability that may arise from the release of such information. I agree that a copy of this authorization may be used in place of the original.

I understand that I retain the right to revoke this consent by notifying the Company in writing at any time except for that action which has already been taken. It shall be effective only long enough to answer the purpose of which it is given and no further confidential information will be released without the execution of an additional written authorization.

_____

Patient and Parent/Guardian's Printed Name if Patient is under 18

_____ _____

Signature Date