ABSOLUTE
PHYSICAL THERAPY

Name: ___________________________

D.O.B.: ____/____/_____

PATIENT CERTIFICATION AND CONSENT FOR SERVICES

- I certify that the information given by me to ABSOLUTE PHYSICAL THERAPY (ABSOLUTE PT) is true and correct to the best of my knowledge.
- I assign to ABSOLUTE PT my right to benefits for services provided by ABSOLUTE PT that my insurer or another payor may be responsible for. Accordingly, I authorize that payment for those services being made directly to ABSOLUTE PT.
- I understand that, as provided for by law, ABSOLUTE PT may release my medical records to my insurer or any other payor who may be responsible for reviewing or paying for all or part of the services provided to me by ABSOLUTE PT, (or to any agent, employee or contractor of my insurer or other payor), if payment of benefits on my behalf is conditioned on receipt of those records.
- I understand that ABSOLUTE PT will make every effort to secure payment for services under any insurance coverage available to me. I understand that I am responsible for paying for any applicable copayments, deductibles or coinsurance. I also understand that I am ultimately responsible for paying in full ABSOLUTE PT billed charges for services I receive for which I have no insurance coverage, and, unless ABSOLUTE PT has agreed in writing to accept partial payment of its billed charges as payment in full, I am responsible for paying any balance due if my available coverage only partially pays for the services I receive from ABSOLUTE PT.
- Absolute PT will add an additional 35 % to any patient's bill that is turned over to collections to cover the cost of collection services..
- I understand that it is my responsibility to contact my insurance carrier to determine the coverage available for services provided by ABSOLUTE PT, and to obtain any authorizations from my insurer or referrals/orders from my Primary Care Physician I may need in order to receive benefits available under my health plan.
- I authorize the staff of ABSOLUTE PT to perform all treatments ordered by my referring physician.
- I acknowledge that I have been encouraged to ask my physical therapist if I have any questions, concerns, and/or comments regarding this certification and consent form.
- The patient must notify ABSOLUTE PT within 24 hours of their scheduled appointment if they are not going to be able to attend at either 942-2233 or 944-2941. If the **patient fails** to do so they will be required to pay a processing / room scheduling fee of **10 dollars**.

PATIENT BILL OF RIGHTS

- The patient has the right to appropriate care and to be treated with respect and consideration at all times.
- The patient has the right to refuse treatment at any time.
- The patient has the right to be informed of and to be involved in his/her diagnosis, plan of care, treatment, and prognosis at all times.
- The patient has the right to expect privacy and confidentiality with regard to treatment received at ABSOLUTE PT, except as otherwise provided above.
- The patient has the right to review and question all bills pertaining to his/her care.
- The patient has the right to voice grievances and concerns to the ABSOLUTE PT without thereby being subject to coercion, discrimination, reprisal, or interruption of service.

My signature below indicates that I have read and understand this certification and consent form, have agreed to its terms and have been provided with a copy for my records if one was desired.

Patient/Legal Guardian Signature ______________________________________ Date: ____________________

Printed Name: ____
(If other than patient, include relationship to patient)

Staff Signature ____ Date: ____________________

Printed Name and Title: ____

Original to AWPT Copy to patient

NORTHEAST PAIN MANAGEMENT, P.C.
ABSOLUTE PHYSICAL THERAPY

Eric Cormier , PT   Christy Stout, PT   Lindsay Duplisea, PT   Michelle Slike, PT

FINANCIAL POLICY

This is an agreement between Northeast Pain Management, P.C., Absolute Physical Therapy, as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Northeast Pain Management, P.C.

By executing this agreement, you are agreeing to pay for all services that are received.

MONTHLY STATEMENTS: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

PAYMENTS: Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within 30 days.

CHARGES TO ACCOUNT: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service. At no point will patients be allowed to carry a balance of more than 500.00.

REQUIRED PAYMENTS: Any co-payments required by an insurance company must be paid at the time of service. Patients with an annual deductible greater than 750.00 will need to provide a deposit of 250.00 at the time of the initial appointment.

INSURANCE: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

PAST DUE ACCOUNTS: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees, which we incur, plus all court costs. In case of suit, you agree the venue shall be in Penobscot County, Maine.

RETURNED CHECKS: There is a fee (currently $25.00) for any checks returned by the bank.

****The Financial Policy continues on the backside of this page. ****

WAIVER OF CONFIDENTIALITY: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

WORKERS COMPENSATION: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

PERSONAL INJURY: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

TRANSFERRING OF RECORDS: You will need to request in writing if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

EFFECTIVE DATE: Once you have signed the acknowledgment of receipt form, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

CONSENT TO TREAT AND AUTHORIZATION TO RECEIVE PAYMENT: By signing the acknowledgment of receipt for this agreement, I consent to treatment by Northeast Pain Management, P.C. and I authorize Northeast Pain Management, P.C. to directly receive payment of benefits from an insurer, managed care organization, governmental agency or other third party that is responsible for payment or arranging for payment of the health care services provided to me by Northeast Pain Management, P.C. I understand that I may be responsible for the payment of the health care services furnished to me by Northeast Pain Management, P.C. even though I may be covered under an insured or other plan arrangement.

Absolute
Physical Therapy

1365 Broadway • Bangor, ME 04401 • (207) 942-2233 • (207) 262-1130 fax

PATIENT HISTORY FORM

Thank you for providing the following important information to help us help you. Please let us know if you have any questions

Patient's Name:______________________________________ Date of Birth:___________ Height__________ Weight ___________

Describe your symptoms: ____

____

When did symptoms begin ____________________________________Was there a surgery: ________Date______________________

How did your symptoms begin: ____

Any falls this year with injury_____________________________

Pain 0/10: Best_____________ Average Daily_________________Worst _________________

What makes your symptoms worse: ____

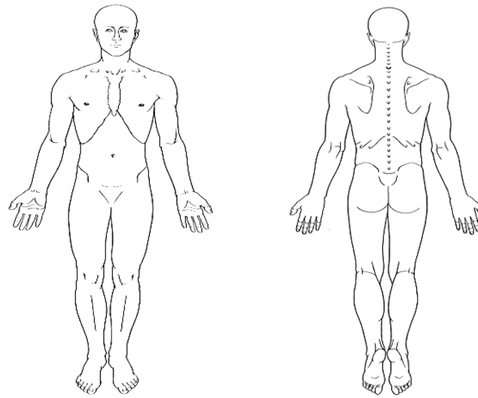
What makes your symptoms better: ____

What treatments have you received: ____

Please mark the diagram to show us your problem areas using these symbols:

NT Numbness/Tingling
A Ache
B Burning
S Sharp
D Dull

Also number the order of importance (1, 2, etc.) next to each area (#1 the most problematic).



INSTRUCTIONS: Put √ in those boxes applicable to you and in the "yes" or "no" space. If lines are provided, write in your answer.

Have you ever had	No	Yes	Please List	Have you ever had	No	Yes	Please List
Cancer				Rheumatoid condition			
Diabetes				Infectious Disease			
Stroke				Thyroid Condition			
Chest pain				Other Surgery			
Pacemaker/defibrillator							

Allergies: ____

Medications: ____

Acknowledgement of Review
Of Notice of Privacy Practices

I have been informed of this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

____

Name of Patient **Date**

____

Signature of Patient or Personal Representative

________I authorize this office to share information with the following, concerning my medical treatment:____
________I authorize this office to leave a message on my answering machine regarding appointments for me concerning my medical treatment.

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Acknowledgement of Review
Of Financial Policy

I have received a copy of this office's Financial Policy. Once I have signed this acknowledgement, I agree to all the terms and conditions contained therein and the agreement will be in full force and effect.

____

Patient's Name **DOB**

____

Responsible Party (if not the patient)

____

Signature **Date**
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Absolute Physical Therapy

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PATIENT INFORMATION FORM

NAME:	SOC. SEC. #:	D.O.B.:
ADR1:	HOME PHONE:	CELL PHONE:
ADR2:	WORK PHONE:	EXT:
CITY:	EMAIL:	
STATE: ZIP:	PRIMARY CARE DR:	
EMERGENCY CONTACT:	PHONE #:	

HEALTH INSURANCE INFORMATION

HEALTH INSURANCE:	
ID/CONTRACT #:	
GROUP #:	
SUBSCRIBER NAME:	
RELATIONSHIP TO SUBSCRIBER:	

AUTO ACCIDENT INFORMATION

INSURANCE COMPANY NAME:	DATE OF INJURY:
	CLAIM #:
MAILING ADR:	LAWYER:
CITY:	PHONE #:
STATE: ZIP:	
TELEPHONE:	

WORKER'S COMPENSATION INFORMATION

INSURANCE COMPANY NAME:	DATE OF INJURY:
	CLAIM #:
ADDRESS:	EMPLOYER:
CITY:	
STATE: ZIP:	LAWYER:
CLAIM #:	PHONE #:
PHONE #:	

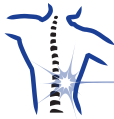
MEDICAL INFORMATION AND PAYMENT AUTHORIZATION

I AUTHORIZE THE RELEASE OF ANY MEDICAL RECORDS NECESSARY TO PROCESS THE ABOVE CLAIM FOR SERVICES RENDERED TO ME BY THE UNDERSIGNED PROVIDER.

SIGNATURE OF PATIENT ______________________________ DATE ______________

I AUTHORIZE PAYMENT OF BENEFITS FOR THE ABOVE CLAIM TO THE UNDERSIGNED PROVIDER.

SIGNATURE OF PATIENT ______________________________ DATE ______________



Absolute Physical Therapy

Northeast Pain Management

Setting the Standard.

Referring provider or facility: ______________________

Provider Upin Number: ______________________

Patient Name: ______________________

Phone: ______________ Work: ______________

Diagnosis: ______________________

Insurance: ______________________

☐ Provide physical therapy evaluation & treatment.

☐ As needed

☐ Other: ______________________

Does insurance require referral? ☐ Yes ☐ No

If yes, Referral numbers: ______________________

Physician Comments: ______________________

____

____

____

____

____

Precautions: ______________________

____

____

Providers Signature: ______________________

Date: ______________

1365 Broadway • Bangor, Maine 04401
207-942-2233 • Fax 207-262-1130 • www.absolutept.net