Manchester Physical Therapy

Effective, professional, individualized treatments to achieve optimal recovery and wellness.

Welcome to Manchester Physical Therapy!

Manchester Physical Therapy was established with the goal of offering our clients an individualized learning experience. Compassionate, one-on -one care, given by highly trained and knowledgeable staff, guides our commitment to providing the best quality care to a diverse population.

HOURS: We have appointments available M-F between the hours of 8:00 to 5:00 depending on the day. We strive to be punctual with all scheduled appointments. We schedule appointments 45-60 minutes depending on patient and therapist preference.

We value your time with us. Manchester Physical Therapy does not "Double Book" patients. Your appointment time is for you alone. Therefore, we request a 24 hour notice when cancelling OR rescheduling an appointment.

Due to covid19 we request that you cancel your appointment even if it is less than 24 hours notice if you are not feeling well.

PAYMENTS:

Co-payments - Per your own plan, co-payments are due at the time of your visit.

Co-insurance - Per your own plan, co-insurance is a percentage portion of your services that you are responsible for. We request a partial payment of $20.00 payment at the time of services towards your balance. You will be provided with a monthly bill of the balance owed to Manchester Physical Therapy.

Deductible - Per your own plan the amount you are responsible to pay before your plan begins to pay for covered services. We request a $50.00 payment towards the deductible and will provide a monthly balance owed to Manchester Physical Therapy.

We expect payments of all outstanding balances to be paid at your next visit. Our billing office personnel will work with you on a payment plan if necessary.

Balances not paid within 30 days of the billing date will be subject to a $5.00 service charge. You will not be able to schedule future Physical Therapy visits with Manchester Physical Therapy if there are any outstanding payments owed.

_____

Patient name (please print)

_____

Signature of patient/guardian date

7254 Rte 7A, Manchester Center, VT 05255-1632 Phone 802-362-1334 Fax 802-362-5344
manchesterphysicaltherapy@gmail.com
www.manchesterphysicaltherapy.com

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Patient Name: _____ Date: _____

DOB: _____ Age: _____ Smoker? Yes No

MD: _____ Problem/Diagnosis: _____

Weight: _____ Height: _____ Date of injury/onset: _____

How did you hear about us? MD___ Friend ___ Family member_____ Other_____

Past Medical History: *Check any condition that you have or had:*

❑ Alzheimer's	❑ High Blood Pressure	❑ Parkinson's
❑ Cardiovascular Disease	❑ History of Cancer	❑ Rheumatoid Arthritis
❑ Cerebral Vascular Accident	❑ Immunosuppression	❑ Traumatic Brain Injury
❑ Current Infection	❑ Lupus	❑ Asthma
❑ Diabetes Type 1	❑ Muscular Dystrophy	❑ Bowel or Bladder Problems
❑ Diabetes Type 2	❑ Obesity	❑ Depression
❑ Fibromyalgia	❑ Osteoarthritis	❑ Lymphedema
❑ Fracture or suspected Fracture	❑ Osteoporosis	❑
❑ Other: _____		

Past Surgical History: _____

Current Medications: _____

Where is your pain (if applicable): _____

What makes your symptoms better? _____

What makes your symptoms worse? _____

My symptoms are currently: ❑ getting better ❑ about the same ❑ getting worse

What treatments have you received for this problem so far? _____

Have you had an x-ray, MRI or other tests for this problem? Results? _____

Is your pain affecting your sleep? Yes No

Pain quality: ❑ dull ❑ sharp ❑ throbbing ❑ burning ❑ache ❑ other: _____

Pain frequency: ❑ less than daily ❑ daily ❑ increases throughout the day ❑ constant
❑ night pain ❑ other:

Using the scale below, enter the number for your pain at its worst _____ best _____ current _____

No Pain — Worst Pain Imaginable

0 1 2 3 4 5 6 7 8 9 10

What are your personal goals for therapy at this time? _____

Have you had any falls in the last 12 months?

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HIPAA Acknowledgement

Is this visit related to (please check one): __a work injury __a motor vehicle accident __a liability claim __none of these

Have you been to Physical Therapy this calendar year, prior to this visit? __ yes __ no

Information for All Patients

Physical Therapy benefits vary greatly from insurer to insurer and plan to plan. It is your contractual obligation to know and follow the rules of your own insurance plan. If you are not sure of these rules, we advise you to call the member services number on your insurance card to confirm what your carrier covers.

Some insurance carriers require a higher co-payment/co-insurance for physical therapy services than for MD office visits. Medical equipment and supplies are often not covered by insurance. Deductibles and coinsurance are the patient's responsibility. Co-pays are due at the time of your visit. We require that patients having a co-insurance, make a $20 payment at the time of service. For patients with an unsatisfied deductible, we require a $50 payment at the time of service (this also applies to patients with coinsurances who have yet to satisfy their deductible). You will be billed for the balance due on your monthly statement. You may pay with cash, check or credit card.

Understanding the nuances of your insurance plan can prevent future problems and we will do what we can to try to assist you regarding this.

For Medicare Patients

1. Medicare does not allow patients to self refer. We can evaluate your needs and write a treatment plan. Your primary care physician must approve that plan for continued care in order for Medicare to pay beyond that initial evaluation. Medicare does not pay for maintenance therapy.
2. Medicare requires that services are medically necessary. Original Medicare covers up to $2040.00 for Physical and Speech therapy services. Medicare will pay 80% of the approved amount and you or your medigap carrier will pay the other 20%. This means that Medicare covers up to $1608.00 (80% of $2040) before your provider is required to confirm that your outpatient therapy services are medically necessary. (Approximately 15-19 visits) Medically necessary services are services that are needed to diagnose or treat your medical condition and that meet accepted standards of medical practice. You will be responsible for 100% of charges applied to your deductible and those over and above what is considered medically necessary. Medicare does not cover maintenance therapy.
3. **Medicare does not allow us to provide physical therapy for patients receiving skilled services from a Home Health Agency.**

Are you currently or have you recently received Home Health Services? _____yes _____no

Authorization to Share Information

My signature below allows Manchester Physical Therapy to discuss my Protected Health Information (PHI) with the following individuals. Any restrictions to their access, if any, are as noted. NOTE: Parents/Guardians of minors (under age 18) are automatically allowed access to PHI.

1. _____ _____
   Name/relationship Restrictions
2. _____ _____
   Name/relationship Restrictions

By signing below, I acknowledge that you, as Manchester Physical Therapy, are adhering to HIPAA rules as mandated by the Federal Government and that I have or have been offered the HIPAA rules to read and/or take with me. I also authorize my insurance benefits to be paid directly to the provider. **I understand that I am financially responsible for any balance.**

_____

Patient Name (please print)

_____ _____

Signature of Patient/Guardian Date

Email address_____

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