Manchester Physical Therapy

Welcome to Manchester Physical Therapy!

Manchester Physical Therapy (MPT) was established with the goal of offering our patients an effective, professional, and individualized treatment plan to achieve optimal recovery and wellness. Compassionate care is provided by highly trained and knowledgeable staff. We are committed to providing the best quality care to our patients.

HOURS:
We strive to be punctual with all scheduled appointments and value your time with us. MPT does not "double book" patients. We schedule 30-60 minutes, depending on patient and therapist preference as well as guidance from what your insurance covers. ***We request 24 hours notice when cancelling or rescheduling an appointment. Failure to do so will result in a $50 fee***. Please do not come into the office if you are ill, exemptions will be made.

BILLING: 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. Medical supplies and equipment are not covered by insurance.

PAYMENTS:
Co-payments - co-payments are a per-service charge due at the time of each visit.
Co-insurance - co-insurance is a percentage charge of your services for which you are responsible. If Physical Therapy services are covered by co-insurance, we collect $20 per visit to off-set your final bill.
Deductible - the amount you are responsible to pay before your plan begins to pay for covered services. If, per your plan, Physical Therapy services are subject to a deductible, we collect $50 per visit to off-set your final bill.

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Consent to Treatment and Assignment of Benefits

I hereby give my permission to MPT (Manchester Physical Therapy) to examine me and administer treatment as is deemed necessary. I hereby assign all benefits directly to MPT. I understand in the event that my insurance does not pay for services I receive, I will be financially responsible for payment.

Patient Name (Please Print)_____

Signature of Patient/Guardian _____ DATE _____

If not signed by patient, please indicate the relationship to patient: _____

Medical Release

I authorize MPT to release information from my medical records to insurance companies, their agents and the Health Care Financing Administration (MCR, MCD) and it's agents for the purpose of determining my medical benefits and for any benefits payable for related services.

Manchester Physical Therapy

I authorize MPT to release and receive medical records between Primary Care and/or Referral physicians and other medical specialists, including personal trainers, for the purpose of coordinating care.
Additional individuals that I allow to discuss my health information, including family members for coordination of care/appointments.

_____ _____
Name/relationship Restrictions

_____ _____
Name/relationship Restrictions

Signature:_____ Date: _____

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Electronic Communications - I consent and state my preference to have, MPT and other staff at MPT communicate with me by email or standard SMS messaging regarding various aspects of my medical care, which may include, but shall not be limited to, dissemination of knowledge, appointment reminders, business developments, promotions, email marketing and billing. I understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS messaging regarding my medical care might be intercepted and read by a third party. I understand that I have the right to revoke this authorization at any time.

Signature: _____Date: _____

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Privacy Practices Acknowledgement

I hereby acknowledge that I have read a copy of this practice's Notice of Privacy Practices.

Signature:_____ Date:_____

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If Patient is a minor or legally incapacitated, please indicate realtionship to patient

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