Your good health is our goal!

Northern Physical Therapy Payment Policy & Billing Procedures

We strive to provide our patients with the utmost professionalism, excellence of service and the guarantee of privacy as mandated by section 164.520 of the HIPAA Privacy Rule (located at Front Desk). Our commitment to your well-being and gain of your physical abilities is something everyone at Northern Physical Therapy takes very seriously and we want you to understand your role in this process:

I understand that payment for all physical therapy services is my responsibility regardless of insurance or other third-party coverage.

I understand co-payment, deductible and co-insurance amounts are to be paid at the time of service. I agree to pay Northern Physical Therapy, PLLC for any unpaid portion of my bill upon request. In the even a check is dishonored, I am responsible to pay Northern Physical Therapy a $35 returned check fee.

I authorize Northern Physical Therapy, PLLC to release to appropriate agencies, any information acquired in the course of my examination and treatment necessary to secure payment for services provided. I also understand that it is my responsibility to understand my health insurance policy and coverage and if special authorization from the insurance company is required prior to initiating physical therapy treatment.

Worker's Compensation and No Fault benefits will be verified however, this does not guarantee payment. In the event of denial, the account will become my responsibility. I can request that Northern Physical Therapy bill my primary insurance and I will be responsible for any unpaid portions of my bill.

If there is a balance on your account, Northern Physical Therapy will send you a statement. All balances are expected to be paid in full upon receipt of statement. Payment not received within 30 days are considered past due and will be subject to late fees and/or interest penalties.

Failure to maintain a current patient account may result in placement of your account with an outside collection agency. I, or my representative, understand and agree that in the event it should become necessary to place my account with an outside collection agency, I will be responsible for collections fees up to 30% of the principal balance owed. In the event that legal action becomes necessary to collect the balance due, I understand that I will also be responsible for attorney fees, interest, and court costs incurred.

Cancel/No Show Policy

_____**(initials)** This is to advise you of our cancel/no show policy. If you cancel or no show for a scheduled appointment without 24 hours notice, you will be subject to a $25 fee. Please understand missing a scheduled visit limits others from receiving services for that day.

________________________________ ________________

Signature of Patient or Guardian Date

203 State Street Ogdensburg
315-393-2025
Fax 315-393-2024

26908 Independence Way Evans Mills
315-629-6255
Fax 315-629-6254

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Northern Physical Therapy

Electromyography Laboratory Authorization & Consent for Testing

Electromyography(EMG) and Nerve Conduction Testing (NCS) are patient services provided in response to a wide variety of medical conditions for patients of all ages, regardless of gender, color, race, creed, national origin or disability.

The purpose of EMG/NCS testing is to evaluate the neuromuscular system and to find diseases that damage the nerves, muscles or the junctions between the nerves and muscles (neuromuscular junction).

All procedures will be thoroughly explained to you. During the NCS, mild electric currents will be applied to the skin on parts of your body. This is done to assess how quickly impulses travel in nerves and the NCS testing may be repeated on several different nerves. The EMG assesses muscle function. A fine needle electrode will be placed under your skin into the muscle being tested. The needle measures the electrical activity in your muscles and it may be repeated on several muscles. You also will be asked to contract your muscle during the EMG.

There are certain inherent risks with EMG/NCS. During the EMG, you may experience some discomfort similar to an injection and may have some residual soreness and bruising for a few days. EMG may also cause false results on muscle enzyme laboratory test and muscle biopsies. There may also be other risks depending on your medical condition: please discuss those with your referring physician or with your electromyographer. During NCS testing, you may feel a shock like sensation as the nerve is stimulated even though the amount of voltage applied is very small. You may feel your muscles twitch. As with EMG testing, there may be other risk depending on your medical condition; please discuss those with your referring physician or with your electromyographer.

Based on the above information, I agree to cooperate fully and to participate in the procedure. I acknowledge that I have read this authorization and agree to be compliant. I acknowledge that I have had the procedures explained to me.

____ __________________

Patient Signature Date

____ __________________

Witness Signature Date

203 State Street Ogdensburg 26908 Independence Way Evans Mills
315-393-2025 315-629-6255
Fax 315-393-2024 Fax 315-629-6254

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The patient is responsible to obtain prior authorization for Physical Therapy from Insurance. The patient is responsible for Deductibles and Co-payments at the time of service and any balances due after insurance has made payment.

Patient Information

Patient Name:___________________________________DOB:_________________SS #:_____________________

Ins. Subscriber's Name:______________________________DOB:______________SS#_____________________

Mailing Address:_______________________________City/State:_________________________Zip:___________

Home Phone:_____________________ Work Phone:___________________ Cell Phone:___________________

Height:____________________ Weight:_________________

Email:____

Is this a Workers Compensation Claim?:_____________ Car Accident?:___________________________________

For Active Duty Military Personnel Only:

Commander's Name and Rank:________________________________Phone#_____________________________

Unit_____________________________ ____

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Present Status:

Please describe your symptoms (i.e. pain, numbness, burning, tingling, coldness, weakness, etc.)

____

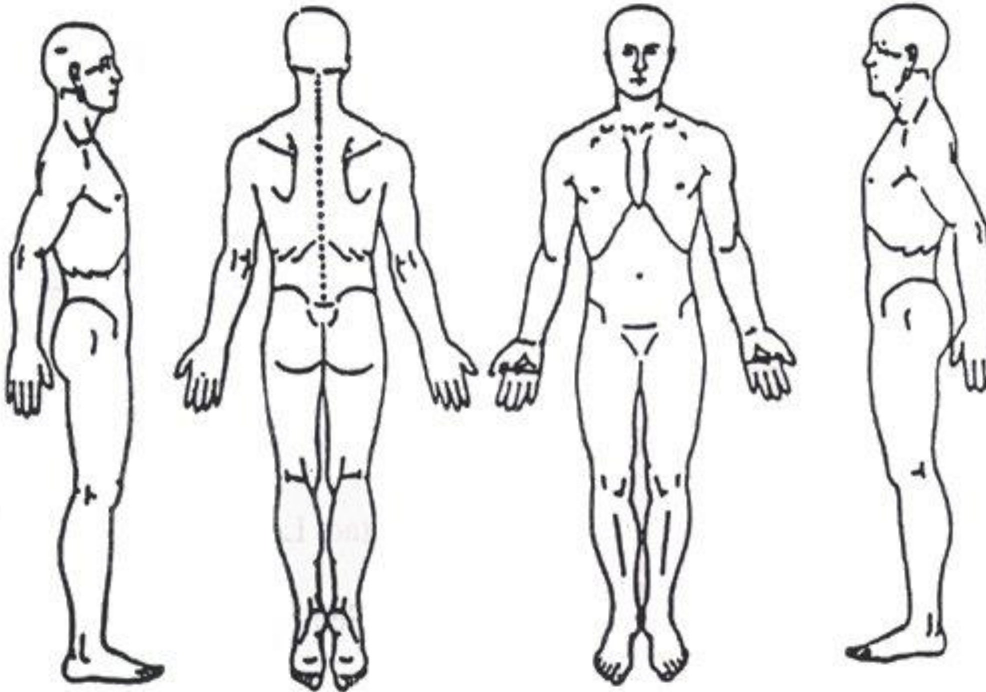
When did your symptoms begin? ____

How frequently do you have your symptoms?
□ Rarely (less than 10% of the day) □ Occasionally (11-25%) □ Intermittently (26-50%)
□ Frequently (51-75%) □ Constantly (76-100%)

Do you have a history of falls? □ Yes □ No Do you drop things often? □ Yes □ No

Do your symptoms get better or worse at night? ____

Please mark on the following diagrams where you have your symptoms:



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Medical History:

Do you have a history of the following medical conditions? (Check all that apply.)

□ Heart Condition □ Coronary Artery Disease □ Peripheral Artery Disease □ Diabetes

□ Pacemaker □ High Blood Pressure □ High Cholesterol □ Thyroid Disorder □ Stroke / CVA

□ Cancer □ Chemotherapy □ Radiation Therapy □ Connective Tissue Disease

□ Asthma □ Neck pain □ Lower back pain □ Disc Herniations □ Arthritis

□ Stenosis □ Neuropathy □ Alcoholism □ Drug Use □ HIV / AIDS □ Hepatitis

□ Other ____

Do you experience any of the following symptoms:? (Check all that apply.)

□ fever, □ chills, □ weight gain, □ weight loss, □ fatigue, □ lack of appetite, □ headache,

□ dizziness, □ fainting, □ shortness of breath, □ chronic cough, □ chest pain, □ palpitations,

□ heartburn, □ abdominal pain or bleeding, □ joint pains or arthritis, □ balance or

coordination problems, □ bladder or bowel incontinence, □ bleeding disorders or anemia,

□depression or anxiety.

Are you a smoker? □ Yes □ No

Please list all medications you are taking: ____

____

Surgical History:

Do you have a history of the following surgeries? (Check all that apply.)

□ Back Surgery □ Neck Surgery □ Joint Replacement □ Amputation

□ CABG / Heart Surgery □ Angioplasty □ Removal of Mass / Cancer □ Other ___________________

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Please review the HIPAA notice provided to you by front desk regarding your diagnostic test.

I (print name)____ acknowledge that my signature below indicates that I have received and have had the opportunity to review the HODS Diagnostic HIPAA notice and ask questions about the policies and procedures contained within.

____ ________________

Signature Date

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