HUDSON VALLEY ORTHOPAEDIC & SPORTS PHYSICAL THERAPY
PAYMENT AGREEMENT FOR
PATIENTS WITH NO-FAULT INSURANCE CLAIMS

Hudson Valley Orthopaedic & Sports Physical therapy is committed to provide you with the best possible care. Please read the highlighted sections below that pertain to your treatment and insurance coverage. If you have any questions, please do not hesitate to ask our staff. The charges for your visits are mandated by the New York State (NYS) Compensation Board and may vary depending upon the treatment you receive during any given visit.

REFERRALS: New York State law requires all patients treated by a physical therapist must be referred by a medical doctor, dentist, podiatrist, physician assistant or nurse practitioner. The referral and /or prescription must be currently dated and in writing. A return visit or call to your referring physician may be required if your therapy is to continue beyond your written prescription. Please discuss your condition with your physical therapist and inform the therapist and/or the desk staff of any scheduled appointment with your referring physician.

As a courtesy to our patients who have sustained injuries from motor vehicle accidents, this office will bill the no-fault carrier responsible for the coverage of your medical bills. You will, if necessary, be responsible for any items purchased during your treatment that are not reimbursed by your no-fault carrier. The insurance carrier responsible for your bills is required to pay within 30 days of receipt of your bill. If we have not received reimbursement within 6 weeks of submission of your bill, we will expect payment in full from you.

If for any reason, including a pending DWI conviction, your benefits are denied or exhausted, we will expect payment in full from you at the time of the denial for all prior services and weekly payments for any services performed thereafter. You may wish to challenge the carrier's decision, but we will not wait for payment pending the settlement of that action or the settlement of legal action on your behalf.

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Date: _____

Patient Name: _____
First Middle Last

Insurance Company Name: _____

Insurance Company Address: _____
Street/PO Box City State Zip Code

Contact Person: _____Phone #_____Fax#_____

Policy Holder's Name: _____
First Middle Last

Policy#_____ Claim#_____

Date of Accident: _____
Month Day Year

When did patient first experience symptoms? _____
Month Day Year

(Continued on reverse side)

□ Was the patient the driver of the vehicle involved in the above-mentioned accident? Yes_____ No_____

□ If yes, is there a pending DWI conviction against the patient or was the patient convicted of DWI with regard to this accident? Yes _____ No_____

□ Is the condition for which the patient is now referred for physical therapy solely a result of the motor vehicle accident? Yes _____ No _____ If no, describe the prior similar condition and list date when the patient experienced the similar symptoms.

_____

_____

□ Was the patient's motor vehicle accident employment related? Yes_____ No_____ If yes, describe this relationship.

_____

_____

□ I understand that I am financially responsible for payment in full if for any reason the no-fault carrier previously named does not cover the charges for my physical therapy treatments.

□ Patient signature: _____

□ Parent or Legal Guardian Name (please print): _____
First Middle Last

Parent or Legal Guardian signature: _____

Relationship to patient: _____

No-Fault Patients: Please list below your private insurance information.

□ Insurance Company Name: _____

□ Insurance Company Billing Address: _____
Street/PO Box City State Zip Code

□ Insurance Company Phone #: _____

□ Name of policyholder if other than the patient: _____
First Middle Last

□ Insurance ID# _____ Group # _____

□ If an employer provides the above named insurance, please name employer: _____

□ If my No-Fault benefits are denied for any of the reasons as stated above, I authorize Hudson Valley Orthopaedic & Sports Physical Therapy to bill my above named private insurance company for my physical therapy treatment.

□ Signature of patient: _____

□ Name of parent or legal guardian: _____
(Please print)

□ Signature of legal guardian: _____