2023 Rates and Financial Policy

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

Our Office gladly accepts Visa, MasterCard, American Express, cash and checks. If you would like to complete a Credit Card Authorization Form, please consult our office staff.

CTDPT accepts the following Insurances: **Anthem BCBS, Aetna,** and **ConnectiCare**
CTDPT is out of network with the following Insurances**: Cigna, United Health Care and Empire BCBS**
CTDPT does not participate with the following insurance: **Husky, Medicaid, Medicare** and **Oxford**

For Patients With Insurance

As a courtesy to our patients with insurance, we will file your medical claims for services rendered. You are responsible for paying any deductible and copayments **at the time of service**. Our office staff makes every effort to be as accurate as possible when collecting these amounts; however, your insurance plan may not cover as much as estimated. Any amount not paid by the insurance is your responsibility. Once we receive payment from the insurance company you will be required to pay the balance due upon receipt of statement. The balance due for services provided of the patients' responsibility, even if the insurance company pays nothing. If you have overpaid your portion, you will receive a refund or payment will be applied to a future date of service for current patients.

For Self-Pay Patients – One-Time Consultations

Self-Pay patients are responsible for payment **at the time of service**. First visit for any diagnosis is $205 - Subsequent visits are $140 per visit. - Consultation Fee $170, Telehealth Fee $90/$85 – Preventative Care/Tune-Ups $150 – Pointe Assessment $145

Delinquent Accounts

We reserve and will exercise the rights to report any account 90 days past due to a Collections Agency. All expenses incurred as a result will be patient's responsibility, as permitted by law.

Cancellations and Missed Appointments

Appointments are valuable blocks of time and when an appointment is missed or cancelled with short notice, we are often prevented from filing that time and helping other patients. Please give at least **24 Hour Notice** when you will not be able to make your appointments. This will allow us the time to help other patients. There will be a charge for all missed and cancelled appointments with less than required 24 hour notice. **Cancellation/No Show Fee $80**

Special Circumstances

Unfortunately, some of our families become involved in divorce. We do our best to provide whatever support we can for the child and the family. First and foremost, however, we are the child's advocate and will not become involved in disputes between the parents except where we believe the child's welfare is at stake. Divorce does not eliminate the parents' financial responsibility for a child's medical care. **It is our policy that the parent or person bringing the child to our office is responsible for payment for services rendered regardless of which parent has the ultimate legal obligation to pay for medical care.** It is the parents' sole responsibility to settle these financial matters between themselves.

By Signing below, I certify I have read, understand, and agree to the rates and financial policy.

Patient Name: ____

Patient Signature: ____________________________________ Date: __________
(Guardian if under the age of 18)

Personal Information

Patients Name: ___________________________________ Date of Birth: ___/___/___ Male ____ Female____

Street Address: ___________________________________ City, State, Zip: ________________________________

Home Phone: (____)-_____-______ Cell Phone: (____)-_____-______ E-mail: ____________________________

____

Referring Physician: _______________________________ Referring Physician Phone: (____)-_____-______

Insurance: ______________________ Policy#: ________________________ Group#: ____________________

Policy Holder: ______________________________ Policy Holder Date of Birth: ____________________________

Emergency Contact: ____ Relationship: ____________________

Phone (H): ___________________________ (W): _____________________________ (C): ___________________

Date of Injury/Accident: __________________ How: ____

Sport/Dance related? Yes _____ or No _____ Car Accident? Yes_____ or No_____ Other: ______________

Is an attorney involved with your case? Yes _____ or No _____

If yes, Name & number of Attorney: ____

Complaint/Diagnosis: ____

Have you seen a Physician? If yes, name of physician: ____

What tests have you had for this injury? _____X-Ray, ________MRI, _____CT Scan, _____EMG, _____,

Other:____

Name of your Primary Care Physician: ________________________________ Date of Last Exam: ____________

Medical History: Have you ever had or currently have?

___High Blood Pressure
___Heart Attack
___Angina
___Shortness of Breath
___Stroke
___Pacemaker
___Cancer: ________________
___Diabetes
___Asthma
___Seizures/Epilepsy
___Fainting Spells
___Frequent Headaches
___Osteoporosis
___Arthritis
___Swollen feet/ankles
___Hearing Loss
___Recent Weight Gain/Loss
___Pregnant? _______ weeks

___Allergies: Type: ____

___Surgeries: Type/Date:____

___Communicable Diseases:____

Medications: (Please list all that you are taking)____

____

How did you hear about Connecticut Dance Physical Therapy: ____

To the best of my knowledge, this form has been completed fully and accurately.

Signature: ____ Relationship: ____________ Date: ___________

Name: (Please Print) _________________________________ Relationship: ___________ Date: ____________