Beth L Maloney, PT, DPT
Physical Therapy, Manual Therapy
Dry Needling, Pilates
Personal Training

Above & Beyond Physical Therapy
10 Martins Ridge Drive
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Physical Therapy Physician Referral Policy

Beth Lepkowski Maloney, PT, DPT, is a certified Direct Access Physical Therapist in the state of Pennsylvania. Under PA State law, a patient is allowed to see a certified Direct Access provider **without a physician's referral** for up to 30 days from the date of the initial evaluation. After 30 days, a physician's referral is required by state law to continue therapy. If you choose to participate in Physical Therapy through Direct Access, we will be happy to collaborate with your overseeing physician after 30 days to obtain referral for continuing therapy.

Non-Participating Provider Policy

Above & Beyond is a "non-participating provider". This means that you are responsible for full payment at the time services are rendered. You may choose to submit your paid receipts to your insurance company for reimbursement (if you have out-of-network benefits). Medicare will not reimburse for any out-of-network services. At each physical therapy appointment you will receive a sales receipt from the previous visit; **this is the only paperwork we will provide if you plan to submit to your insurance company.** Each receipt will have your diagnosis codes and treatment codes on it. These are the codes the insurance company will need. **If you plan to submit for reimbursement, it is your responsibility to contact your insurance provider before your first visit to be sure you understand your benefits in this situation and to request any additional paperwork/authorizations that the insurance company may require.** In addition, many insurance companies require a referral for physical therapy from a physician before your first visit or for pre-authorization to qualify you for reimbursement.

These policies are in place so that Above & Beyond can provide the highest quality of individualized care available.

Physical Therapy Registration

Today's Date:_____

How Did You Hear About Above & Beyond?

____MD Referral ____Insurance Co. ____Friend ____ Website ____Other

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Referring MD: _____Telephone Number:_____

Address:_____

Patient's Name:_____Date of Birth:_____Age:____

Patient's SSN: _____Telephone:_____ (Cell/Home)

Address:_____City:_____ St:_____ Zip:_____

Employer:_____Work Tele:_____

Emergency
Contact:_____Tele:_____

If under 18 filing under parent's insurance:

Parent's
Name:_____SSN:_____Tele:_____

Does parent live at same address as above? If not:

Address:_____City:_____ St:_____ Zip:_____

Insurance Co: _____ ID#:_____ Group#:_____

Address:_____Tele:_____

Subscriber's Name:_____Self:_____ Spouse:_____ Parent:____

Subscriber's Date of Birth:_____

Date of Injury: _____

We are unable to treat injuries associated with Auto Accident or Workers Comp claims

It is necessary for us to keep a copy of your medical information on file.

Office Policies

A full list of Above & Beyond's Office Policies and Pricing can be reviewed at:
www.aboveandbeyondpt.com

Consent for Treatment

The patient hereby consents to the administration of appropriate evaluation and therapeutic procedures by Above and Beyond.

I have reviewed the above Physician Referral, and Non-Participting Provider policies, as well as the Office Policies listed at www.aboveandbeyondpt.com. I fully understand that payment is due when services are rendered. I understand that I will be responsible for filing my own medical insurance claims if I choose to submit charges to my insurance for reimbursement. I understand that if I have Medicare the services provided by Above & Beyond are not able to be submitted to Medicare for repayment and are non-reimbursable through Medicare. I agree to accept full financial responsibility for medical expenses incurred at Above & Beyond.

Patient's Signature:_____

Date:_____

If patient is under 18 years of age and a parent is not able to attend sessions of physical therapy with the minor, the parent(s) signature for authorization allows Above & Beyond to commence physical therapy treatments with the patient who is a minor. The parent(s) is also accepting full financial responsibility for the treatment.

Parent's Signature: _____
(If patient is under 18 years old)

Date:_____

Patient Information Form

Name: _____ **Age:** _____

Occupation:_____

Reason for visit: ▫ Physical Therapy ▫ Personal Training ▫ Pilates

Medical History:

General Health (check one): ___Excellent ___Good ___Fair ___Poor

Have you had any **medical problems** or hospitalization in the past year (circle)? Yes No

If "yes", please specify:

1._____

2._____

3._____

Surgical History:

Procedure:_____

Date:_____

Procedure:_____

Date:_____

Procedure:_____

Date:_____

Prescriptions/Medications:

_____

Over-the-counter Medications:

_____

Tobacco: Yes No If yes, please specify ppd: _____ years: _____

Alcohol: Yes No If yes, please specify: amount/day, week, or month: _____

Caffeine: Yes No # drinks/day _____

PAST INJURY/PROBLEM HISTORY

Date	Injury/Problem	Whom Seen	Treatment	Recovery Time
1.				
2.				
3.				
4.				
5.				

Present Injuries/Problems (if applicable):

Date of Injury/Onset:_____

Body Part(s): _____

Mechanism of Injury/Onset:_____

_____

Type of Onset (check one): ____Gradual ____Sudden

Symptoms at the time of onset:_____

_____

_____

Current symptoms: _____

Positions/activities that **aggravate** symptoms:

1._____

2._____

Positions/activities that **relieve** symptoms:

1._____

2._____

Present/Past Medical Conditions (circle):

Asthma	Y	N	Heart Attack	Y	N
Arthritis	Y	N	Heart Disease	Y	N
Cancer	Y	N	Hernia	Y	N
Chemical Dependency	Y	N	High Blood Pressure	Y	N
Circulatory Disease	Y	N	Kidney Disease	Y	N
Depression	Y	N	Metal/Other Implant	Y	N
Diabetes	Y	N	Multiple Sclerosis	Y	N
Dizziness	Y	N	Nervous Disorder	Y	N
Eating Disorder	Y	N	Numbness	Y	N
Emphysema	Y	N	Osteoporosis	Y	N
Epilepsy	Y	N	Pregnancy	Y	N
Fainting	Y	N	Stroke	Y	N
Fatigue	Y	N	Thyroid Problems	Y	N
Headaches	Y	N	Tuberculosis	Y	N
Hepatitis	Y	N	Weakness	Y	N
Fever/Chills/Sweats	Y	N	Night Pain	Y	N
Unexplained Weight Change	Y	N	Dyspnea	Y	N
Nausea/Vomiting	Y	N	Dysuria	Y	N
Bowel Dysfunction	Y	N	Sexual Dysfunction	Y	N
Urinary Frequency Changes	Y	N			

Comments: _____

Has anyone in your immediate family been treated for any of the conditions listed above? If yes, please specify: _____

Current Recreational/Fitness Activities:

1._____

2._____

3._____

Goals for P.T./Pilates/Personal Training:

1._____

2._____

3._____

Where is your pain?

Please mark on the drawings below the areas where you feel your pain.