Bellaire Physical Therapy
6708 Ferris Street
Bellaire, Texas 77401
Ph: 832-588-3552
Fax: 281-402-3077

EIN 90-0625475
www.BellairePT.com
Physical, Occupational, Speech Therapy
Orthopedics & Neurology // Land & Aqua
Geriatrics // Pediatrics // Drivers Rehab

Welcome to Bellaire Physical Therapy

We are committed to providing you with a high-quality rehab experience. We understand that you chose to work with us because of our excellent reputation in the medical community. Please take a few minutes to read through this letter so that you can understand the policies of our office. If you have any questions, please ask us! We want you to feel comfortable here and get the most out of your time, effort, and money.

Insurance Price Sheet
This list explains the cost of services. Your insurance company determines the amount of money you need to pay us for physical therapy. Some insurance companies only pay enough for 30 minutes, while others reimburse for 45 minutes. Some insurance companies even pay for an hour of therapy. Please look for your fee agreement in your initial paperwork packet.

Scheduling
There are only 12 appointments available for each therapist per day. When you schedule your appointment, that time slot is no longer available for anyone else. This prevents double bookings which would result in the therapist treating you and another patient during the same time slot. Because there is only one (1) patient per appointment slot, we apply a $45.00 no show or cancellation fee to reduce the loss from a missed session. You may cancel 24 hours before your appointment with no fee, or you may reschedule your appointment for another time and day with no fee. We would like to see you for your session rather than charge a missed visit fee, and we will be as accommodating as we can to make that happen.

Choosing a Therapist
Each of our therapists has unique skills, and we encourage you to request a particular PT for your follow up appointments. Dr. Lieberman divides his time in the office by evaluating and treating patients as well as providing mentorship to the other therapists to help develop professional growth. Abraham would prefer to treat each patient, however, this would require that he be at the office 150 hours a week. We prefer to have every 3rd visit scheduled with Dr. Lieberman for treatment input.

Insurance will only allow for a re-evaluation every 30 days. If you wish to consult with Dr. Lieberman, a $50 fee is charged in addition to your co-pay or co-insurance. Insurance does not reimburse for consultations between evaluations.

Treatment Style

Every physical therapy facility has a “style.” Bellaire PT’s style is to conduct a thorough evaluation to determine the cause of your problem and to create a high quality and evidenced based plan of care to help you meet your goals. Our treatment sessions are 45 minutes long and this does not include any modalities such as ice or heat, TENS, or ultrasound. Initially we will introduce you to corrective exercises and we will build a home program for you so you can perform these on your on your own, and we will use our subsequent clinic time to provide manual therapy, manipulation, dry needling, re-education, gait training, and functional training. Our aim is to use our time together in the office to advance and correct your program, so you will need to perform your exercises at home or the gym. However, that is up to you. The better you keep to your program, the better you will do with your recovery!

Photo Release

We ask you to consider allowing us to use your image for the purpose of education or marketing. Please sign our waiver if you give consent.

PT Ratings and Online Review

We depend on you to tell us how we are doing. Please rate your therapist after every session. We encourage you to leave positive reviews on Google or Yelp for others to benefit. Please mention your review, and we will have a small gift ready for you to enjoy as a token of our appreciation for your time.

Billing and Collections

We use a billing and collections company to manage our financial intake. Please accept our apologies in advance if you receive an invoice or bill that is different from what you expected. Don’t get excited or upset! This is usually an error, or a delay in your account being updated. Please talk to us if you have any questions or concerns.

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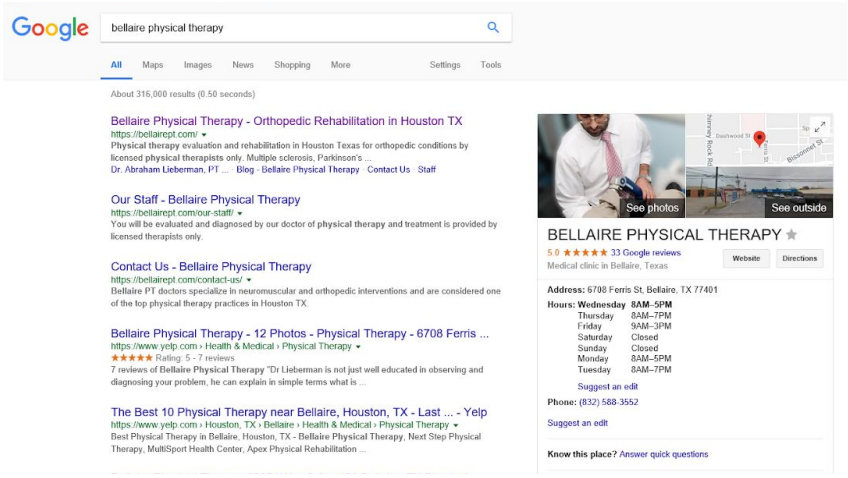
Leave us a Google Review!

In the Google search bar, type in “Bellaire Physical Therapy”



Then click on the blue “Google reviews” on the right-hand side next to the yellow stars

Click on the link to leave us a review

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Therapist Performance Rating Tool

At the end of each session, we would appreciate it if you could take a moment to answer a few questions about your visit. It will help us improve our patient care, and your form is submitted anonymously.

Please select your therapist for today's session

- Dr. Abraham Lieberman, PT, DPT
- Dr. Denaye Eby, PT, DPT
- Dr. Danielle Shindler, PT, DPT
- Chani Stewart, OTR
- Kelsey Wade, BS, PTA
- Cornelius Provost, BS, PTA

Session began on time

- Yes
- Somewhat
- No

Therapist explained exercises and purposes

- Yes
- Somewhat
- No

Therapist addressed your concerns

- Yes
- Somewhat
- No

Therapist was attentive

- Yes
- Somewhat
- No

Therapist was hands-on

- Yes
- Somewhat
- No

Therapist seemed prepared

- Yes
- Somewhat
- No

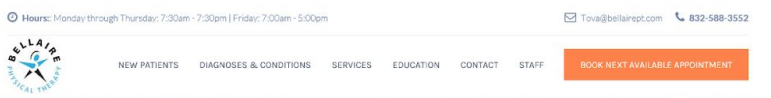
Therapist confirmed next appointment

- Yes
- No

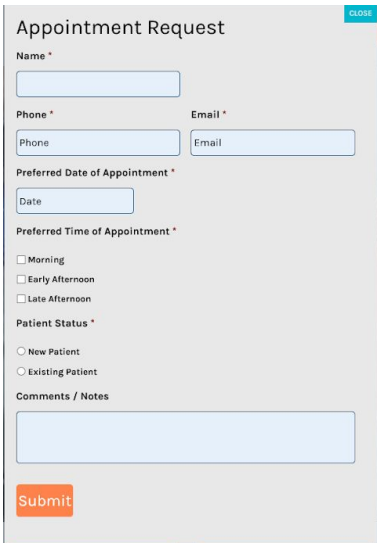
Thank you very much for your time today. We appreciate you helping us to do a better job helping you!

How to use our online appointment scheduler

Open a new webpage and go to www.BellairePT.com where you will see our orange scheduling widget on the homepage.



You will see the following pop-up. Please complete your information, click Submit, and a member of our team will contact you to set up an appointment.



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Office & Financial Policies

Consent:

- _____I consent to participate in physical therapy services at STAR Spine Therapy & Amputee Rehabilitation, PLLC, DBA Bellaire Physical Therapy. I acknowledge that participation in physical exercise and rehabilitation may involve the use of exercise equipment and devices and poses potential risks of bodily injury or death.
- _____I hereby accept the responsibility for any harm, injury, or damage that may result from my participation in physical exercise and/or training. I hereby waive, release, absolve, indemnify, and agree to hold harmless STAR Spine Therapy & Amputee Rehabilitation, PLLC, DBA Bellaire Physical Therapy, it's officers, employees, and affiliates for any claim arising out of any injury to me as a result of negligence or any cause. I voluntarily and knowingly acknowledge, accept, and assume these risks.
- _____I understand that the practice of physical therapy, although strong efforts are made to utilize best practice, is not an exact science and that no guarantee or promises have been made to mea as a result of treatments or examinations by the physical therapist or supportive personnel. I understand that no contract, warranty, guarantee, or promises concerning the results of physical therapy services is made.

Release of Information:

- _____STAR Spine Therapy & Amputee Rehabilitation, PLLC, DBA Bellaire Physical Therapy releases patient healthcare information for purposes of treatment or payment or to other healthcare organizations as outlined in our "Notice of Privacy Practices." I authorize the release of any medical, financial, or other information pertinent to my case to any insurance company, adjuster, attorney, or third-party payer involved in this case for the purpose of processing claims and securing payment of benefits.
- _____I have read the "Notice of Privacy Practices" and understand that a copy of the notice will be provided to me upon my request.

Insurance and Payment:

- _____I authorize the staff at STAR Spine Therapy & Amputee Rehabilitation, PLLC, DBA Bellaire Physical Therapy to obtain and review my health insurance coverage in the manner that it is available from my insurance company.
- _____I understand that my insurance benefits are only a quote of benefits and are not a guarantee of payment. I understand that it is my responsibility as a patient to know my insurance coverage and that insurance coverage is an arrangement between the carrier and the patient.

- _____I acknowledge that I will be ultimately responsible for payment for services rendered at this facility. I agree to pay in full any and all charges not covered by insurance or other benefits. I understand that it is unlawful to waive copays, co-insurance, and deductibles that are my responsibility.
- _____I authorize payment to be made from my insurance company directly to STAR Spine Therapy & Amputee Rehabilitation, PLLC, DBA Bellaire Physical Therapy for services rendered.
- _____I agree to pay my bill at the time of service unless other arrangements have been made with the Billing Department.
- There will be a fee of $25.00 assessed to your account for returned checks.
- _____I understand that if my financial arrangement is not fulfilled as agreed, my account will be transferred to an outside agency to assist in collecting the remaining balance. A 35% fee will be added to the unpaid balance and will be my financial responsibility.

Late Cancellation/No Show Policy:

- _____Please make every effort to be on time for your appointment. If you are late, your therapist may not have sufficient time to treat you, or your therapy time may be reduced. Please call the office if you know that you will be late. You may be asked to reschedule your appointment.
- _____If you must change or cancel your appointment, please call 24 hours in advance. Same-day cancellations and no-show appointments are liable to a $45.00 charge to your account.
- _____I understand that it is my responsibility to keep track of my scheduled appointments. I understand that it is a courtesy of the office to send me a patient appointment reminder. I will contact the office with any questions regarding my schedule.
- _____If you have 3 consecutive last-minute cancellations or no-show appointments, we will have to remove your recurring appointments from our calendar. Consistent no-shows will result in the termination of the therapist/patient relationship.
- Our policy is to maintain a credit card on file for each patient. We respectfully request that you provide a card to be charged in the event a cancellation or no-show fee must be assessed. Please find our credit card authorization form included in this packet.

Communication:

- _____Our office prefers to use email and digital communication to notify patients of appointment reminders and changes as well as office updates. I hereby consent to receive email and/or text message communications. **Please clearly print your email address if you consent to using email for these preferred communications:**
- **Email address: _____**
- **Cell phone number: _____**

Photography & Video Release:

- _____I hereby grant permission to the rights of my image, likeness, and sound of my voice as recorded on audio or videotape without payment or any other consideration.
- _____I understand that my image may be edited, copied, exhibited, published, or distributes and waive the right to inspect or improve the finished product wherein my likeness appears.
- _____I waive any right to royalties or other compensation arising or related to the use of my image or recording.
- This material may be used in diverse educational settings within an unrestricted geographic area. By signing this release, I understand this permission signifies that photographic or video recordings of me may be electronically displayed via the Internet or in the public educational setting. There is no limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed. This release applies to photographic, audio, or video recordings collected as part of the sessions listed on this document only.
- _____I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.

I have read and understand the above office and financial policies and agree to be bound by these terms. I also understand and agree that STAR Spine Therapy & Amputee Rehabilitation, PLLC, DBA Bellaire Physical Therapy may amend such terms from time to time.

_____

Print Name Signature Date

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Credit Card Authorization

We know that your time is important, and we appreciate that you have chosen Bellaire Physical Therapy for your rehabilitation. We try to be punctual with our schedule and ask that you do the same. We understand that things come up last minute and that you may need to cancel an appointment now and then. If you are able to reschedule, you can avoid the $45.00 cancellation fee. However, appointments canceled with less than 24-hour notice as well as no-show appointments will incur a $45.00 cancellation fee charged to your credit card on file. We would prefer not to have to charge you, and we encourage you to come to your scheduled sessions.

Please complete the credit card authorization below. This information will be kept secure and confidential.

_____ _____

Name on Card Billing Zip Code

_____ _____

Credit Card Number Expiration Date

_____

Card Security Code

_____ _____

Signature Date

_____

Printed Name