

PATIENT INFORMATION

| | | | | | | | |
|--------------------------|-------|-------------------------|-----------------|-----------------------|--------------|------------|------------|
| Evaluation Date: _____ | | Referring Doctor: _____ | | Primary Doctor: _____ | | DOB: _____ | |
| Patient: _____ | | SS# _____ | | Marital Status: _____ | | Sex: _____ | |
| Last | First | MI | | | | | |
| Email: _____ | | Main Phone: _____ | | Alt Phone: _____ | | | |
| Address: _____ | | | City: _____ | | State: _____ | | Zip: _____ |
| Emergency Contact: _____ | | | Relation: _____ | | Phone: _____ | | |

****Please note we submit claims only to your carriers. We do not handle third party claims (other persons, lawyers, etc).****

| | | | | | |
|-------------------------------------|--|-------------------------|--|----------------------------|--|
| Primary Insurance Co: _____ | | Insured Person: _____ | | Relation: _____ | |
| Phone #: _____ | | Insured SS#: _____ | | Insured DOB: _____ | |
| Group #: _____ | | ID/Claim/Policy#: _____ | | Adjuster's Name/Ph#: _____ | |
| Secondary Insurance Co: _____ | | Insured Person: _____ | | Relation: _____ | |
| <i>(N/A if none)</i> Phone #: _____ | | Insured SS#: _____ | | Insured DOB: _____ | |
| Group #: _____ | | ID/Claim/Policy#: _____ | | | |
| Tertiary Insurance Co: _____ | | Insured Person: _____ | | Relation: _____ | |
| <i>(N/A if none)</i> Phone #: _____ | | Insured SS#: _____ | | Insured DOB: _____ | |
| Group #: _____ | | ID/Claim/Policy#: _____ | | | |

Please indicate if your injury is related to any of the following:

| | | | | |
|---|------------|-------------------|---------------------------------|-----------------------------------|
| _____ Motor Vehicle Accident | YES | NO | if yes, date of accident: _____ | State accident occurred in: _____ |
| initial | circle one | | | |
| _____ Work/Job (Worker's Compensation): | YES | NO | if yes, date of injury: _____ | |
| initial | circle one | | | |
| Worker's Comp Only: | | | | |
| Employer: _____ | | Occupation: _____ | | Work Phone: _____ |
| Employer Address: _____ | | City: _____ | | State: _____ Zip: _____ |

| | |
|---|--|
| Previous treatment (including chiropractic and other physical therapy services)? Yes or No (circle one) | |
| If yes, when/where? _____ | |
| Describe symptoms/injury/diagnosis: _____ Date of injury/onset: _____ | |
| Have you had surgery for this condition in the past year? Yes or No (circle one) Type: _____ Date: _____ | |
| Have you received or are you currently receiving Home Health care for ANY REASON ? Yes or No (circle one) | |
| If yes, you must be DISCHARGED from Home Health PRIOR to receiving services from our clinic. | |
| Home Health Agency Name: _____ Phone: _____ | |
| Date of Discharge: _____ Please indicate if your injury is related to any of the following: | |

FINANCIAL POLICY

Welcome to the Orthopedic & Sports Physical Therapy Center, LLC. We would like to take this time to help you understand our financial policy. We feel that a clear understanding of the financial involvement is essential before beginning treatment.

Payment is expected as services are rendered unless other prior arrangements have been made. We accept personal checks, VISA, MASTERCARD, DISCOVER, and cash as forms of payment. Please feel free to discuss payment plans with our patient accounts manager. We will try to provide you with an estimate of cost.

If you have insurance, we will submit claims on your behalf to your primary and/or secondary/tertiary insurance. After verification of your insurance coverage and benefits, you will be expected to meet your deductible, pay your copay/coinsurance and any services not covered by your insurance carrier. If we have not received payment from your insurance company within a reasonable amount of time and/or you fail to provide us or the insurance company with requested information to process your claim, the balance will then become your responsibility.

Orthopedic & Sports Physical Therapy Center, LLC does not accept/bill third party claims. We do not bill accounts to lawyers or any other persons. We also do not bill any other person's insurance company. You are expected to make payments on your account regardless of a third party responsibility and/or pending lawsuit. All medical information will be provided to the patient upon request.

I hereby authorize Orthopedic & Sports Physical Therapy Center, LLC (to include professional staff) to treat me for my condition. _____
initial

I hereby authorize Orthopedic & Sports Physical Therapy Center, LLC to release my records and any medical information necessary to process this claim. _____
initial

I authorize payment of medical benefits to the Orthopedic & Sports Physical Therapy Center, LLC for services rendered. I understand that insurance policies are an agreement between an insurance carrier and me. I understand that I am financially responsible for payment of all services rendered, unless otherwise provided by law. _____
initial

I understand that (1) payment is due in full upon receipt of the billing statement unless other payment methods have been agreed upon by both parties, (2) failure to make payment when due can result in the account being turned over to a collection agency, (3) I am responsible for paying interest and all costs of collection efforts, including a reasonable attorney's fee. _____
initial

I understand there will be a \$50.00 charge for a missed appointment or a cancellation of less than 24 hours (excluding last-minute emergency cancellations). _____
initial

I understand there will be a \$20.00 charge for any returned check, and this amount is above the amount of the check and must be paid by money order or cash promptly. _____
initial

I have read and agree to the above terms of the Orthopedic & Sports Physical Therapy Center, LLC's Financial Policy.

Signature of Patient or Patient's Parent/Guardian

Initials

Date

For patients under 18, credit card information to be retained on file:

Card Number

Expiration Date

Name on Card