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 <u>your carriers</u>. 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:_____
(N/A if none) Phone #:_____Insured SS#:_____Insured DOB:_____

Group #:_____ID/Claim/Policy#:_____

Tertiary Insurance Co: _____Insured Person: _____Relation:_____
(N/A if none) 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#_____

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 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: _____

_____
Patient Name

FINANCIAL POLICY

Payment is expected as services are rendered unless other prior arrangements have been made. We accept personal checks, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS and cash as forms of payment. For patients under 18, we require a credit card on file. Please feel free to discuss payment plans with our patient accounts manager. We will try to provide you with an ***estimate*** of cost.

It is expected that all insurance information is given to our office staff BEFORE treatment begins. We will not file claims to your insurance company if you did not originally give us this information.

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 $20.00 charge for any returned check, and this amount is above the amount of the check and must be paid promptly by money order or cash. _____
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 age 18, credit card information to be retained on file:

_____ _____
Card Number Expiration Date

_____
Name on Card