



**Medicare Patients Only:**

Have you received outpatient PT this calendar year? **Yes** **No**

**Patient Information**

**Today's Date:** \_\_\_\_\_

**Name:** \_\_\_\_\_ **SS#** \_\_\_\_\_

**Male/Female** **Date of Birth:** \_\_\_/\_\_\_/\_\_\_

**Address:** \_\_\_\_\_  
Street City State Zip

**Home Phone:** ( ) \_\_\_-\_\_\_ **Cell Phone:** ( ) \_\_\_-\_\_\_ **Work Phone:** ( ) \_\_\_-\_\_\_

May we leave a message on voice mail or with someone answering these numbers in regards to your care? **Yes** **No** **Would**  
you like to receive appointment reminders via text message? Yes, tify me by text. No,  not text me.

**Email Address:** \_\_\_\_\_

Would you like to receive appointment reminders by email? Yes, notify me by email No, Do not email me

**Is this a work related injury?**Yes, Please complete Worker's Compensation Information Sheet  No.

**Is this injury due to a motor vehicle accident?** Yes, Please complete Auto Accident Information Sheet  No.

**Claim # for Workers Comp/Auto** \_\_\_\_\_

**Name of Health Insurance Policy Holder if not yourself:** \_\_\_\_\_

**Date of Birth of Insurance Policy Holder:** \_\_\_/\_\_\_/\_\_\_

**Emergency Contact:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_ May we release protected health information to this person?  **Yes**  **No**

**Consent for Treatment**

I hereby consent to and authorize all therapy treatments, which may be considered medically necessary and/or advisable, for the diagnosis and/or treatment of the patient named above at Advanced Physical Therapy and Fitness.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Parent or Legal Guardian must sign if patient under 18 years of age)

**Acknowledgement of Privacy Policy Statement**

I acknowledge that I have received or reviewed the Privacy Statement from Advanced Physical Therapy and Fitness.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Parent or Legal Guardian must sign if patient under 18 years of age)

**Insurance Authorization and Assignment**

I authorize release of any information regarding my(or my child's) healthcare, advice and treatment for the purpose of evaluation and administrating claims for insurance benefits. I also hereby authorize payment of insurance benefits payable to me, direct to Advanced Physical Therapy and Fitness.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Parent or Legal Guardian must sign if patient under 18 years of age)

**Medicare Patients Only:** I request that payment of authorized Medicare benefit be made on my behalf to Advanced Physical Therapy and Fitness for any services furnished to me by that supplier. I authorize any holder of medical information about me to be released to the Centers for Medicare and Medicaid Services(CMS) and its agents, if needed to determine these benefits or the benefits payable for related services:

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Financial and Insurance Policy

We are committed to providing you with the best possible care. If you have insurance, we make every attempt to assist you in receiving your maximum allowable benefits necessary for your care. In order to achieve these goals, we need your assistance and understanding of our payment policy.

We will bill your primary insurance. This can only be accomplished with a completed insurance form and signed assignment of benefits form. At the time of service, co-payments and co-insurance are due in full, unless other payment arrangements have been made in advance by our staff. We accept cash, check, Visa or MasterCard. For those without insurance benefits, or when your benefits have become exhausted, payment for services is due at the time services are rendered, unless prior arrangements have been approved in advance by our staff.

**Returned checks and balances older than 30 days will be subject to additional interest charges of 2% per month. In addition, if there is no payment on an open account for 30 days, a \$15 late fee service charge will be added, and if there is no payment on an open account for 90 days, it will be turned over to collections with a 30% collection fee added. Any patient with a patient balance greater than \$50.00 upon discharge from physical therapy will be required to pay balance or to set up a payment plan with our staff.**

**There is a \$50 charge for no-show appointments and returned checks.** This fee is not billable to insurance and will be your responsibility. Please call in advance to cancel any appointments you are unable to attend.

We will gladly discuss your treatment program and answer questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies and therefore, are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage of "UCR." "UCR" is defined as usual, customary and reasonable fees for this region. Thus, our fees are considered usual, customary and reasonable by most companies.
3. Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover. If you receive an uncovered service, you are responsible for payment for that service.

We must emphasize that as physical therapy providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients (required for Medicare patients), all charges are your responsibility from the date services are rendered. Should temporary financial problems arise that would affect timely payment of your account, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding your insurance coverage, please don't hesitate to ask us. We are here to help you.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Patient or Responsible Party