NEWSOME PHYSICAL THERAPY NETWORK

PATIENT INFORMATION **Date**______________

Name____ M_____F_____ DOB___________ SSN_____________________

Address____H Phone__________________C Phone__________________

E-Mail_________________________________Employer______________________________Wk Phone_________________

Emergency Contact:______________________Number_________________How did you hear about us?______________

REFERRAL INFORMATION

Physician_______________________Phone________________FAX_____________Address___________________________

Rx Date____________ Diagnosis____

Frequency/Duration__________________________ Date of: Symptom/Injury___________ Date of Surgery___________

INSURANCE INFORMATION

Job Related_________ Auto Accident________ Attorney Name___________________________ Phone________________

Primary Ins. Co. _________________Policy Holder _____________________DOB_________Relationship to Pt___________

ID#____________________________Group/Account#_______________________Insurance Phone___________________

Insured's Employer___________________________ Insured's SSN______________________ Eff. Date____________

Medicare 60 Day Home Health or Hospital_____________________ Phone_______________ Dates__________________

Secondary Ins. Co. ________________ Policy Holder _____________________DOB_________Relationship to Pt__________

ID#___________________________Group/Account#__________________________Insurance Phone__________________

Insured's Employer_____________________________ Insured's SSN_______________________ Eff. Date_____________

WORKER'S COMPENSATION

Employer_______________________________ Contact Name____________________________ Phone________________

WC Carrier___________________ Adjuster_____________________ Phone____________ Claim#_____________________

Case Mgr______________________ Phone_________________ Comments____

AUTO ACCIDENT

Carrier______________ Phone____________ Claim#_______________ Policy Holder_____________________ Lien? Y N

OFFICE USE ONLY Verified by___________ Date__________ Initials__________ PreCert_____________________________

IN Deductible____________ Met________ %Payable_________ Copay__________ OOP____________ Met________

OUT Deductible____________ Met________ %Payable_________ Copay__________ OOP____________ Met________

Limits/Comments____PT used_____OT used______

Mail Bill To____

Appt. Date__________________ Time____________ Clinic______________ Therapist______________ Initials___________

NEWSOME PHYSICAL THERAPY NETWORK
FINANCIAL POLICY

Insurance/Worker's Compensation: We will bill your insurance company once your insurance coverage has been verified. Your benefits will be explained at the initial visit and any deductibles, co-payments or percentage due will be collected each visit. All pre-authorized worker's compensation claims will be sent directly to your worker's compensation carrier. If your insurance company fails to pay within 60 days of the date of service we will expect you to pay the balance in full, and seek reimbursement from your insurance company.

Medicare: We are a Medicare certified facility and we will file a claim to Medicare on your behalf. You will be responsible for any co-insurance, deductibles and non-covered expenses.

Private Pay: Payment in full is expected when services are rendered. A payment plan can be set up on your behalf if necessary. You will be expected to honor the payment agreement in order for treatment to continue.

PATIENT CANCELLATION / NO SHOW POLICY

Your scheduled appointment is a specific time your therapist has allotted for you. It is important to be timely. If you are unable to attend, you must notify the clinic in advance of your appointment time and reschedule the missed appointment. Failure to attend your session may hinder your recovery process as well as disrupt the schedule of your therapist. Cancellation or failure to attend (3) consecutive appointments may result in your being discontinued from physical therapy. A $20.00 cancellation fee may be charged for a no show / no call appointment.

If you are covered by worker's compensation and consistently fail to keep your appointments as were recommended by your physician, the appropriate parties (physician, employer, insurance company, rehab consultant) will be notified of your absence by phone or in writing.

Patient Signature____ Date____________________________________

AGREEMENT TO PAY

I understand the financial policy as stated above. I understand that I am responsible for all charges regardless of my existing medical coverage or payment plan. If payment is forwarded to me I will forward payment to you. I understand that I am responsible for meeting insurance deductibles, co-insurance and non-covered services. If the account becomes past due, the balance becomes my responsibility and is immediately due. I also agree to pay all collection costs incurred, in an amount not to exceed (50%) of the unpaid balance. Should any unpaid balance be referred to a collection agency or referred to an attorney for litigation, all reasonable attorney fees and court costs shall be paid for by the undersigned as allowed by the Court.

Estimated Insurance Benefits: ______%
Estimated Patient Portion: Deductible: ______ Co-Payment: ______ per visit or ______% Annual Maximum: __________

Patient or Responsible Party Signature: ____ Date: _______________________

Print Name:____

CONSENT FOR TREATMENT/RELEASE OF INSURANCE ASSIGNMENT/MEDICAL INFORMATION

Yes___ No___ I, hereby authorize the above provider to render any and all therapy service or other related service, that the provider feels are necessary or advisable to the patient in conjunction with the physicians referral.

Yes___ No___ I assign payment of medical benefits directly to the provider.

Yes___No___ I authorize the release of any medical information necessary to process this claim to insurance company representatives. I also give my authorization to release my records, progress notes and verbal reports if/when needed. I also authorize the request of an appeal or a fair hearing with my insurance or Medicare carrier if payment is denied.

Patient or Responsible Party Signature:____Date: _________________________