



# Patient Information Form

DATE: \_\_\_\_\_

ACCT#: \_\_\_\_\_

NAME: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

DOB: \_\_\_\_\_ MALE [ ] FEMALE [ ]

PHONE#: \_\_\_\_\_

HOME#: \_\_\_\_\_ CELL#: \_\_\_\_\_

PRESENTLY WORKING: YES [ ] NO [ ]

SOCIAL SECURITY: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

E-MAIL: \_\_\_\_\_

MARITAL STATUS: S M D W

ELIGIBLE FOR MEDICARE: YES [ ] NO [ ]

WOULD YOU LIKE TO BE CONTACTED VIA TEXT MESSAGE? YES [ ] NO [ ]

EMERGENCY CONTACT: \_\_\_\_\_ PHONE#: \_\_\_\_\_

HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

### INJURY INFORMATION

WORK RELATED INJURY? YES [ ] NO [ ]

MOTOR VEHICLE ACCIDENT? YES [ ] NO [ ]

DATE OF DISCOMFORT: \_\_\_/\_\_\_/\_\_\_

PREVIOUS PHYSICAL THERAPY? YES [ ] NO [ ]

MEDICAL CARE IN THE HOME? YES [ ] NO [ ]

### INSURANCE INFORMATION (for office use only)

**PRIMARY INS:** \_\_\_\_\_

POLICY HOLDER'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

POLICY HOLDER'S DOB: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

POLICY HOLDER'S EMPL: \_\_\_\_\_

PHONE NO: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

POLICY #: \_\_\_\_\_

GROUP #: \_\_\_\_\_

EFFECTIVE DATE: \_\_\_/\_\_\_/\_\_\_ DEDUCTIBLE: \_\_\_\_\_ OOP: \_\_\_\_\_

VERIFIED BY: \_\_\_\_\_ REFERRAL/ AUTH# : \_\_\_\_\_ VISITS ALLOWED: \_\_\_\_\_

INSURANCE: \_\_\_\_\_% PATIENT CO-INS: \_\_\_\_\_% PATIENT CO-PAY: \$ \_\_\_\_\_

**SECONDARY INS:** \_\_\_\_\_

POLICY HOLDER'S NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

POLICY HOLDER'S DOB: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

POLICY HOLDER'S EMPL: \_\_\_\_\_

PHONE NO: \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

POLICY #: \_\_\_\_\_

GROUP #: \_\_\_\_\_

EFFECTIVE DATE: \_\_\_/\_\_\_/\_\_\_ DEDUCTIBLE: \_\_\_\_\_ OOP: \_\_\_\_\_

VERIFIED BY: \_\_\_\_\_ REFERRAL/ AUTH# : \_\_\_\_\_ VISITS ALLOWED: \_\_\_\_\_

INSURANCE: \_\_\_\_\_% PATIENT CO-INS: \_\_\_\_\_% PATIENT CO-PAY: \$ \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_

DIAGNOSIS CODE: 1. \_\_\_\_\_

NPI: \_\_\_\_\_

2. \_\_\_\_\_

RX DATE: \_\_\_\_\_

THERAPIST: \_\_\_\_\_

3. \_\_\_\_\_



## FINANCIAL POLICY

Thank you for choosing our practice for your physical therapy needs. In order to establish excellent communication and avoid any misunderstanding, we have put together our financial policies for your review.

### **INSURANCE:**

As a courtesy to our patients, we will provide you with an itemized statement for patient reimbursement; or we will submit insurance claims for you, at no charge, provided you have given us the complete information of your insurance including policy/claim numbers and any other information necessary to expedite your claim. Please understand that this is a courtesy. You are still responsible for any charges incurred. This may include any balance left that your insurance does not cover. You will be expected to pay the amount that your insurance does not cover at each treatment. You will also be asked to assign benefits to us or our billing entity so that payment will be made directly to our office.

### **INSURANCE PERCENTAGES:**

Each time you come in after you have finished your treatment for the day, we kindly ask that you stop by the reception desk to make sure you have paid any percentages owed for that day's treatment.

### **INSURANCE CO-PAYS:**

If your insurance plan requires you to pay a co-pay, the co-pay must be paid before treatment is administered.

### **DOUBLE INSURANCE:**

If you are insured with two or more insurance companies, we will submit claims to your primary and secondary insurance carriers only at no cost, provided you bring us the Explanation of Benefits or EOB from the primary carrier after they have paid so that it can be sent to your secondary insurance. If you have met all deductibles required by your insurances and your supplement plan coordinates benefits with your primary insurance, no money will be collected at the time of your treatment; you are responsible for the balance left if, for some reason, the insurance company does not cover the total charges.

### **MEDICARE:**

We do accept assignment on Medicare claims. This means that we will use Medicare's fee schedule when billing for services. Medicare will pay 80% of the charges and you will be responsible for the 20% balance, which we

collect at the end of each treatment. You will be treated only with what we understand to be Medicare acceptable procedures. There is still the possibility that Medicare will not accept all or a portion of your treatment. In that case, you will be given a written notice. At that time, you can decide whether to continue with your treatment or not.

**MEDICARE AND SUPPLEMENTAL INSURANCES:**

We do accept assignment on Medicare claims. You will not have to pay a percentage at the time of your treatment providing all deductibles are met and your supplemental plan covers the 20% Medicare does not pay; however you are responsible for any percentage balance not paid by your supplemental insurance(s).

**REFUNDS:**

Refunds are not given until the financial balance has been paid in full.

**WORKER'S COMPENSATION:**

We accept worker's compensation claims provided it has been by the workers compensation insurance carrier. If false information is given and it proves not to be a worker's compensation claim, you will be responsible for any charges incurred.

**LEGAL CASES:**

Whether represented by an attorney for either a work related injury, motor vehicle accident or any other reason, the patient is still responsible for charges incurred, If you have group health insurance, we would prefer you file under that carrier instead of waiting until your claim is settled by your attorney or insurance.

**THANK YOU**

We thank you for you for choosing our practice for your physical therapy needs as well as your cooperation with our financial policies. Please feel free to discuss any questions with us either by phone or in person at our client relations desk prior to your initial visit.

Along with lasting results, our goal is to give you the best overall physical therapy experience from the moment of first contact until the last day of your physical therapy treatments.

I \_\_\_\_\_ voluntarily consent to abide by these financial policies. I am aware that I will be responsible for any balance not covered by my private or commercial insurance.

Patient, POA, Parent or Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_



## Physical Therapy Consent For Treatment

I voluntarily consent and authorize the clinical staff of Tier 1 Physical Therapy and Sports Medicine to evaluate, administer, perform and carryout any and/or all procedures ordered by my referring physician or my dependent's referring physician in addition to being determined appropriate by the treating physical therapist. I understand that all care will be administered by or directly supervised by a Texas Licensed Physical Therapist. I understand that any information I choose to withhold may adversely affect my treatment rendered. I understand that there is no guarantee as to the results of the treatment rendered. I agree to participate in my physical therapy treatment program as an active participant. I also understand I will be given the opportunity to discuss any questions or concerns I have in regard to my treatment with the treating licensed physical therapist.

\_\_\_\_\_

**Patient, POA, Parent and/or Guardian**

\_\_\_\_\_

**Date**