PRN PHYSICAL THERAPY **PATIENT INFORMATION**

CLINIC NAME: SUMMIT PHYSICAL THERAPY

RX DATE_____________ SCHD APPT _____________ TX START DATE _____________ THERAPIST________________________

NAME ____ SOCIAL SECURITY #____________________

ADDRESS ________________________________CITY__________________ STATE______ ZIP____________

HOME PHONE ( ) _______________ MOBILE ( ) _______________ WORK PHONE ( ) _______________ Ext_____

DATE OF BIRTH ____________________ MARITAL STATUS __________________ PATIENT SEX: _______________

PERSON TO CONTACT IN CASE OF EMERGENCY ____

RELATIONSHIP ________________________________ PHONE ______________________________

REFERRING PHYSICIAN ____ PHONE ____________________

DATE OF INJURY OR SURGERY _______________ DIAGNOSIS ______________________ICD #________

CAUSE OF COMPLAINT DUE TO: ❐ AUTO ❐ WORK ❐ OTHER______________________________

NAME OF INSURED/ POLICY HOLDER

NAME _________________________ RELATIONSHIP TO PATIENT _____________ SOCIAL SECURITY #__________________

EMPLOYER NAME ____ PHONE ____________________________

INSURANCE INFORMATION Do you have a secondary insurance? ❐ Yes ❐ No

PRIMARY

NAME OF INSURANCE COMPANY ____

BILLING ADDRESS: ____

PHONE ( )__________ - _______________ REPRESENTATIVE ____

POLICY/ ID# ______________________________ GROUP# ______________________ EFFECTIVE DATE: ____________

BENEFITS ________% DEDUCTIBLE __________ MET _______ COPAY $________ OUT OF POCKET MAX__________________

REQUIRES PRE –AUTH: ❐ YES ❐ NO AUTH# ______________________________ # OF VISITS AUTHORIZED ________

AUTHORIZED BY _________________DATE ______________PLAN LIMITATIONS: ________________________________

SECONDARY

NAME OF INSURANCE COMPANY____PHONE #_________________________

INSURANCE BILLING ADDRESS: ____ DOB:__________________

POLICY HOLDER: ____ RELATIONSHIP TO PATIENT________________________

SOCIAL SECURITY/ MEMBER ID# __________________________________ GROUP#______________________________

WORKERS' COMPENSATION / AUTO INFORMATION

NAME OF INSURANCE COMPANY____ PHONE # ______________________

ADDRESS TO SUBMIT CLAIMS____

ADJUSTER______________________________ PHONE# __________________________ FAX# _________________________

DATE OF INJURY_____________ CLAIM# ______________________________ PREVIOUS PT/OT (This Injury) ❐ YES ❐ NO

EMPLOYER____ PHONE# ___________________________

AUTO PATIENTS ONLY : POLICY HOLDER: __________________________________ RELATIONSHIP:____________________

AUTO POLICY #________________________________ MED-PAY ON POLICY: ❐ YES ❐ NO AMOUNT $_____________

MEDICARE PATIENTS ONLY

DO YOU HAVE MEDICARE PART A & PART B? ❐ YES ❐ NO

HAVE YOU RECEIVED HOME HEALTH WITHIN THE LAST 2 MONTHS? ❐ YES ❐ NO

ARE YOU CURRENTLY RECEIVING ANY TYPE OF THERAPY AT ANOTHER FACILITY OR HOSPITAL? ❐ YES ❐ NO

HAVE YOU PREVIOUSLY RECEIVED PT/OT FOR THIS DIAGNOSIS? ❐ YES ❐ NO

Insurance Benefits and Payment Policy: The information listed above is a description of your healthcare benefits, which was given to us by a representative of your health insurance company. It is not a guarantee or authorization of payment. Actual benefits cannot be determined until the claim has been received and processed by your insurance. We will call to verify your insurance coverage. Deductibles and co-payments are due at the time of service.

I hereby give lifetime authorization for payment or insurance benefits to be made directly to this healthcare provider for services rendered. I understand that I am financially responsible for all charges not paid by my insurance company. In the event of default, I agree to pay all costs of collection and reasonable attorneys fees. I further agree that a photocopy of this agreement is as valid as the original. I further authorize that my signature on this form constitutes assignment of benefits to the above name healthcare provider.

I consent to have this healthcare provider and/or its' affiliates provide the treatment and care prescribed by my physician(s). I understand this consent may be revoked by me at any time.

____ ______________________________

PATIENT'S SIGNATURE DATE

Insurance Verification and Billing

The support staff of Summit Rehabilitation L.L.C. will bill your insurance company once you have provided us with a completed intake sheet and copy of your insurance card. Verification of eligibility and benefits for physical therapy is provided as a ***courtesy*** to you. However, you are ultimately responsible for prompt and full payment for all services provided.

Office co-payments and/or contributions towards annual deductibles are due at the time of service. Contributions to annual deductibles are partial payments only. You may receive a bill for the remaining balance.

Cash Pay Accounts

Payment is due at the time of service.

Patient Attendance Contract

We value you and your time and take pride in the fact that we try to schedule appointments that are most convenient for our patients. Summit takes steps to ensure that you are treated quickly and efficiently when you arrive for your appointment.

In order to keep everyone's schedule running smoothly, ***it is extremely important that you arrive on time for your appointment.*** Being late may result in your appointment being rescheduled due to lack of time for a productive treatment.

Therefore, we request that you provide 8 hour notice for cancellations. Cancellations with less than 8 hour notice and "No-Shows" may be subject to a $25 cancellation fee, due at the next visit. Please be aware that medical insurance companies do not cover any cancellation fees. Thus, ultimate payment is the responsibility of the patient.

I have read the above policies and procedures and understand my responsibilities.

Patient Signature____Date_____________________

(Parent or guardian's signature if patient is a minor)