Four Pines Physical Therapy, PC

Patient Information Sheet

Last Name_______________________________ First Name______________________ MI_____SSN___________

Mailing Address___________________________________City__________________ST_____ZIP______________

Home Phone___________________________ Cell Phone ________________________ Work________________

Date of Birth______________________Gender___Email____

Appointment reminders: Voice______ Email______

Emergency Contact (please list one not living at home)

Name_______________________________Phone_______________________Relation______________________

Address_____________________________ City__________ST_______Zip Code________ Cell______________

Name _______________________________________ Phone_______________ Relation____________________

Address_______________________________ City___________________ ST___ Zip________ Cell_____________

Employer__________________________________Phone_________________________

Address____________________________________City_______________________ST______Zip______________

Problem Description____ Date of Injury____________________

Worker's Comp Case Worker_________________________________ Phone _______________________________

Date if Motor Vehicle Accident_________________ State Accident Occurred in __________At Fault?_______

Referred by______________________________ Primary Dr. ________________________Phone_____________

Primary Insurance__________________________________ Policy Id#___________________________________

Subscriber_________________________________Relationship_______________________Date of Birth________

Secondary/Supplemental Insurance________________________________Policy#_________________________

Subscriber____Relationship________________Date of Birth_______

I authorize release of Information requested by my Insurance plan for Payment.
I authorize release of information to My Referring Physicians and Lawyer if needed for MVA.
I Understand that I am responsible for any balance due. Accounts with balance will be subject to interest rate of 1.75% after 60 days
I agree to comply with the terms and conditions as outlined on the Patient Registration form.
I hereby acknowledge that I have received a copy of the Notice of Health Insurance Privacy Policies Act.

Patient/Guarantor____Date______________________

Four Pines Physical Therapy, PC

Payment/Insurance Policy

For your Convenience, We will bill All Insurance companies. Complete and accurate Insurance information plus a copy of your card must be provided at time of service. We suggest you contact your Insurance to know your coverage. Any non-covered services are your responsibility and payment is required at time of service. We will accept payment directly from your insurance company with the following provisions:

1. Patient agrees to provide insurance information to Four Pines Physical Therapy's PT.'s and Staff.
2. Patient authorizes notice to the insurance company of assignment below.
3. If Insurance company pays you directly, you have 10 days to provide us with the explanation of benefits and the amount paid by the Insurance.

In the absence/cancellation/denial by the Insurance Co., the patient is responsible for the account. Unpaid Accounts **90** days past due will be sent to an outside COLLECTIONS Co. In addition to unpaid portion of account, the patient is responsible for collection fees and interest charges on the past due account.

Finance Charges of 1.75% per month (Annual Percentage rate 21%) will be calculated each month on the unpaid balance before adding new purchases. Total balance maybe paid in Full at any time without penalty or additional Finance Charge. Initial____________

I give permission to this office, it's service providers, collection agencies, successors and assigns to email/dial/text/leave a message on any phone/voicemail/email address of any phone (home and cell phones)and Emails provided by or otherwise owned by me or my spouse which may be include the name of company dialing the call, regarding services provided and my financial obligations regarding those services.

Appointment Cancellation Policy: We require a minimum of 24 hrs advanced notice of cancellation of a scheduled appointment. A $**45.00** fee will be charged for **No Show** or **Cancellation** less than 24 hour notice.
Emergencies that require canceling a scheduled appointment will be handled on a case by case basis. Initial__________

Notice to the Insurance Company of Assignment

You are instructed to pay clinic directly, at the billing address on the claim form, for all professional services. This instruction to you is an assignment of my rights to the extent of the bills. Any sum of money paid under this assignment shall be credited to my account. This assignment is subject to the financial arrangements with the clinic as set forth above.
In the event you make payment to me, Please add the clinic's name to all checks. I agree to immediately remit all such payments to the clinic.
I hereby authorize the Insurance Co. to provide the clinic with any information regarding the processing and payment of my insurance claim.

I have read and understand the Financial Policy for Four Pines Physical Therapy, PC
I authorize treatment by the Staff of Four Pines Physical Therapy, PC
I authorize payment of Medical Benefits to undersigned provider or supplier for these services and all future claims.
I authorize the release of any medical information necessary to process this claim and all future claims

Patient/Gaurantor____Date_______________