NORTH SANTA ROSA
Physical Therapy

Date _____ Referring Doctor _____

PATIENT INFORMATION

_____
First Name Last Name Middle Initial Nickname

_____ Gender: M F _____ Marital Status: S M D W
Social Security # Circle One Birthdate Circle One

RESIDENCE/CONTACT INFORMATION

_____
Street Address

_____
City State Zip Email Address

_____ _____ _____
Home Phone Cell Phone Alternate #

For appt. reminders, please contact me via: Email Text Call May we leave messages on your voicemail? Y N
Circle one or more Circle one

May we discuss your condition with another person? Y N If yes, who? _____

EMPLOYER INFORMATION

_____
Employer Name

_____
Street Address City State Zip

_____ _____ _____
Phone Fax Position Title

EMERGENCY CONTACT INFORMATION

_____
Name Phone # Relationship

Is this injury work or auto related? Y N Which one? _____ Attorney? Y N Name: _____
Circle One Circle One

INSURANCE INFORMATION

Auto * WC * Private _____: See "Insurance Information" Form

Medicare: See Card

Secondary _____: See Card

Self-Pay: Evaluation $100.00; Follow-up $80 / $85

ASSIGNMENT OF BENEFITS: *Authorization to Pay* ***North Santa Rosa Physical Therapy***
I hereby authorize my insurance benefits to be paid directly to NORTH SANTA ROSA PHYSICAL THERAPY and I authorize NORTH SANTA ROSA PHYSICAL THERAPY to release any information necessary to process my claims. I acknowledge that I am financially responsible if my benefits are terminated or retro-actively denied; for any non-covered services; as well as for any costs associated with collection, should such action become necessary (this is **not** applicable to worker's compensation cases).

SIGNED _____ DATE _____

********** ↓ For Office Use Only ↓ **********

PT _____ _____
(Lay Case Description)

☐ Illness ☐ injury: DOI _____

☐ auto ☐ home ☐ motorcycle ☐ rec ☐ school ☐ work/NC

DX 1 _____

DX 2 _____

DX 3 _____

North Santa Rosa Physical Therapy
Financial Policy

We are pleased to have the opportunity to work with you and your doctor in providing you with a quality physical therapy program. We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship.

Private or Group Insurance: Please refer to the "Insurance Information" Sheet.

Medicare: We accept "assignment". This means that we will accept Medicare's *allowed fees* for physical therapy services. For these services, Medicare pays 80% of the *allowed fees*. If you have a supplemental, we will bill the 20% balance to the supplemental. If you do not have a supplemental, you are responsible for the 20%, which is **estimated** at approx. $20-25 per session.

Workers Compensation/VA: Prior-authorization must be obtained from the insurance company before we can schedule appointments.

Motor Vehicle Accidents: If you have medical coverage on ***your auto insurance policy***, we will bill that for you. If you don't have medical benefits on your auto policy, please provide your health insurance information. We, as a medical provider, ***cannot bill the other party's auto insurance***, ***even if they are at fault***.

Lien Cases: We do not take lien cases.

Missed Appointments: We require **24 hours notice** if you cannot keep your appointment. There is a **$20.00 fee** for a **MISSED APPOINTMENT** (defined as a **cancellation with less than 24 hours notice** or a **no-show**). This fee must be paid at your next visit.

- ➔ After a missed appointment, we will not hold your next scheduled appointment unless we have direct confirmation from you.
- ➔ After 3 missed appointments, we will need to discuss scheduling alternatives with you. Also, we reserve the right to remove all future appointments from our schedule until we can discuss the alternatives with you.

Thank you for understanding our Financial Policy. Please do not hesitate with any questions.

Responsible Party Signature X _____ **Date** _____