

ID Checked _____

Orthopedic and Sport Therapy Services

Patient Information: (Please print)

Cell Phone: () _____

Mr. Mrs. Ms. _____ Phone: () _____

Address: _____ City: _____ State: _____

Mailing: _____ City/State: _____ Zip: _____

email: _____

Date of Birth: _____ SSN: _____ Single _____ Married _____ Student _____

Employer: _____ Phone: () _____

Address: _____ City/State _____ Zip: _____

Job Title/Position: _____ Shift: _____

Referring Physician Name: _____ Phone: () _____

Address: _____ City/State: _____ Zip: _____

Next MD Appointment: _____ **PCP Name (if different):** _____

Other Treating Physician's: _____

Medical History:

Please list current medications including vitamins and over-the-counter medications: _____

Surgeries: _____

Allergies: _____

Do you smoke: _____ Packs per day: _____

Do you have any of the medical conditions listed below? Please circle if positive:

Cardiac Condition

Diabetes

Asthma

Cancer

High Blood Pressure

Any chance you're pregnant?

Fall Risk Intake:

Do you experience unsteadiness or loss of balance while walking? _____

Have you fallen in the past year: _____ If yes, how many times: _____

If yes, what was/were the date(s) of your fall? _____

Do you experience dizziness or vertigo? _____

If yes, what treatment was rendered? _____

PT USE ONLY:

No action required: _____

PT/OT intervention: _____

PT INT: _____

Accept: _____

Declined: _____

Do you have an ongoing 3rd party litigation for this condition: Employment Automobile Accident

WORKERS' COMPENSATION OR AUTO INSURANCE INFORMATION

Insurance Company Name: _____ Claim #: _____

Address: _____ City: _____ State/Zip: _____

Claim Representative: _____ Phone: _____

Date of Accident/Injury: _____ State Accident/Injury Occurred: _____

Primary Medical Insurance:

Insured Person's Name: _____ Phone: (____) _____

Address: _____ City/State: _____ Zip: _____

Date of Birth: _____ SSN: _____ Employer: _____

Relationship to Patient: Self ____ Spouse ____ Parent ____

Secondary Medical Insurance:

Insured Person's Name: _____ Phone: (____) _____

Address: _____ City/State: _____ Zip: _____

Date of Birth: _____ SSN: _____ Employer: _____

Relationship to Patient: Self ____ Spouse ____ Parent ____

PLEASE SIGN BELOW

Patient's or Guardian's Signature

I authorize the release of any medical or other information necessary to process this claim.

Signed: **X** _____ Date: _____

Insured's or Authorized Person's Signature

I authorize payment of medical benefits to Orthopedic & Sport Therapy Services for physical therapy services provided to patient.

Signed: **X** _____ Date: _____

REFERRALS

If your insurance coverage is an HMO plan, requiring authorization for treatment from your Primary Care Provider (PCP), we will assist you in maintaining a current treatment authorization; however, you must be aware that it is primarily your responsibility to know the limits on duration of treatment that your PCP has authorized and to work with your physician's office in obtaining extensions, should they be necessary, on authorizations that may expire during the course of treatment.

INSURANCE BILLING

As a courtesy to our patients we will submit all claims for your treatment to your insurance carrier(s). We will verify your insurance coverage and notify you of any deductible and/or estimated co-payment amounts for which you are responsible.

ATTORNEY LIENS

It is the policy of this clinic **not** to accept attorney liens in the case of automobile accidents or other injuries involving litigation. In most cases your own auto insurance and/or health insurance will cover your treatment until the limits of your policy have been reached.

CANCELLATION POLICY

All appointments must be canceled twenty-four (24) hours in advance. We would appreciate your compliance with this policy, as someone else may be able to use your reserved time. If you have canceled more than twice you may be billed \$25 for further cancellations and your therapist will consider discontinuing your treatment.

MISSED APPOINTMENT POLICY

If you miss your appointment, you will be removed from our treatment schedule. We will reschedule your missed appointment after you contact our office; however, if you miss any further appointments, treatment will be discontinued and you will be billed \$25 for your missed appointment.

RETURNED CHECK FEE

There will be a \$25.00 fee for any check returned unpayable.

COLLECTION FEES

If your account is forwarded to the collection agency, you will be responsible for the balance owed at the time it is forwarded plus any fees charged by the agency, which can range from 32% - 50% of your outstanding balance.

If you have questions or concerns regarding any of the above policies, please feel free to discuss these with our office staff.

I have read the above statements and fully understand the policies of Orthopedic and Sport Therapy Services regarding insurance claims and my responsibilities, physician referrals, cancellations, missed appointments and payment of any balance owed. My signature acknowledges that I agree to the terms of this statement regarding payment for services and authorize Orthopedic & Sport Therapy Services to treat the named patient.

Signed: **X** _____ Date: _____
Patient or Legal Guardian

We have been informed by your health insurance carrier that your benefits for treatment are as follows:

This information was given to us by your insurance company and is not a guarantee of benefits.

Calendar year deductible \$ _____ of which \$ _____ has been met, leaving a remaining deductible due of \$ _____. After this deductible has been satisfied, the remaining charges will be processed at _____ percent. Therefore, the co-insurance for which you are responsible to pay will be approximately \$ _____ per visit.

Your insurance requires no deductible. Your co-pay responsibility for each visit is \$ _____.

When the patient is a minor dependent of divorced parents, the parent accompanying the child to the appointment will be responsible for payment of any balance due.

THIS SECTION FOR ORTHOPEDIC & SPORT THERAPY USE ONLY

Primary Insurance:

Insurance company: _____ Date verified: _____

Person spoken to: _____ Date of eligibility: _____

PCP referral required: _____ Referral received: _____ PCP on file w/insurance: _____

Deductible amount: _____ Amount met: _____ Co-Pay/Co-Insurance: _____

Maximum benefit limit: \$ _____ or Visits _____ Used to date: _____

Out of pocket max: _____ Amount met: _____

Preauthorization/Precert required: _____ Number of visits approved: _____ Auth. date: _____

Letter of medical necessity required: _____ Iontophoresis (CPT #97033)covered: _____

ORTHONET AUTH: _____

REMARKS: _____

Secondary Insurance:

Insurance company: _____ Date verified: _____

Person spoken to: _____ Date of eligibility: _____

PCP referral required: _____ Referral received: _____ PCP on file w/insurance: _____

Deductible amount: _____ Amount met: _____ Co-Pay/Co-Insurance: _____

Maximum benefit limit: \$ _____ or Visits _____ Used to date: _____

Out of pocket max: _____ Amount met: _____

Preauthorization/Precert required: _____ Number of visits approved: _____ Auth. date: _____

Letter of medical necessity required: _____ Iontophoresis (CPT #97033)covered: _____

ORTHONET AUTH: _____

REMARKS: _____

