Premiere
Physical Therapy & Sports Rehab

PATIENT INFORMATION

Patient Name: (First) _____ (Last) _____ (MI) _____

Address: _____ **City, State, Zip:** _____

Home #: _____ **Cell #:** _____ **Work #:** _____

Please note whether we have permission to leave a detailed message on your answering machine if we are unable to reach you in person.

Home: Yes No Cell: Yes No Work: Yes No

Social Security #: _____ **Date of Birth:** _____ **Sex:** M / F

Status: Single Married Divorced Other **Email Address:** _____

Diagnosis or chief complaint: _____

Date of Injury: _____ **Did you have surgery?** Yes No **If yes, when?** _____

Referring Doctor: _____

Patient's Employer: _____ **Patient's Spouse or Parent:** _____

How did you hear about us? (Please circle one):

Doctor Friend/Relative Return Patient Phone Book
Website Internet search Insurance List Other: _____

In case of an emergency, please contact:

Name: _____ Phone #: _____ Relationship: _____

Guarantor Information (responsible for payment, if other than patient):

Name: _____ Phone #: _____ Relationship: _____

Address: _____ City, State, Zip: _____

Additional Insurance Information:

Worker's Comp Claim #: _____ Case Manager: _____

Auto Claim #: _____ Insurance Adjuster: _____

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Patient Name: _____ **Date:** _____

CONSENT: I do hereby agree and give my consent for **Premiere Physical Therapy & Sports Rehab** to furnish Therapy Treatment. _____(Please initial)

Premiere Physical Therapy & Sports Rehab has my permission to allow students to observe my treatment and care.

Yes _____ NO _____(check yes or no)

RELEASE OF INFORMATION: I agree that **Premiere Physical Therapy & Sports Rehab** may disclose my "protected health information" (PHI) in compliance with HIPAA Privacy Provisions which may include my medial records, to any third party payers, including , but not limited to health insurers, health care service plans, state and federal agencies, workers compensation carriers. This includes appropriate release and disclosure of my medical records in compliance with Privacy Provisions to my physicians and other health care providers when necessary for my treatment and general health. While I am in the facility for treatment and care, the facility has permission to disclose pertinent information to family members, friends, or designated caregivers who may be present with me. I understand that if I am not present in the facility, my personal health information will not be disclosed unless I agree to disclosure.

PLEASE LIST BELOW ANY OTHER PEOPLE WITH WHOM YOU AUTHORIZE OUR OFFICE TO DISCUSS YOUR PHI and/or BILLING INFORMATION.

Name: _____ Relationship _____ PHI _____ Billing _____

Name: _____ Relationship _____ PHI _____ Billing _____

HIPAA PRIVACY NOTICE: I acknowledge that I have received **Premiere Physical Therapy & Sports** Rehab HIPAA Privacy Notice and have had the opportunity to review its content. _____ (Please initial)

FINANCIAL POLICY STATEMENT: As a courtesy we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any co-payments at the time of service. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. If any payments are made directly to you for services billed by us, you recognize an obligation to promptly remit same to **Premiere Physical Therapy & Sports Rehab.**

The above does not apply for those patients that are considered Workers' Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Note: Estimated coverage information is provided as a courtesy to our patients, but it is not intended to release them from total responsibility for their account balance.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ _____

Patient/Guardian/Responsible Party **Date**

_____ _____

PPTSR Representative/Witness **Date**