



Please type or print clearly and complete ALL sections.

PATIENT INFORMATION FORM

Date: _____

Patient Name: LAST FIRST MI Nickname: _____

Mailing Address: STREET APT CITY STATE ZIP

Street Address: (IF DIFFERENT) STREET APT CITY STATE ZIP

Sex: Male Female Marital Status: Married Single Widowed Divorced

Date of Birth: Social Security Number: _____

Home Work Phone: Ext: Cell Phone: _____

Email Address: _____

Is patient employed? Yes No Full-time student Position/Grade: _____

Employer/School: _____

Address: STREET APT CITY STATE ZIP

Spouse's Name: LAST FIRST MI Work Phone: _____

Spouse's Birthdate: Spouse's Social Security Number: _____

Referring Physician: NAME ADDRESS PHONE

Primary Care Provider: NAME ADDRESS PHONE

Emergency Contact: (FRIEND OR RELATIVE NOT LIVING WITH YOU) RELATION TO PATIENT PHONE

Have you or a member of your family been a patient here before? Yes No If yes, who? _____

INSURANCE INFORMATION: Please complete, even if you give us a copy of your insurance card to ensure proper billing.

Primary Insurance/claim: Group #: Member ID #/Claim #: Mailing Address: Phone Number: Policyholder's Name: Policyholder's Date of Birth: Policyholder's Social Sec #: Policyholder's Employer: Relationship to Patient:

Secondary Insurance: Group #: Member ID #/Claim #: Mailing Address: Phone Number: Policyholder's Name: Policyholder's Date of Birth: Policyholder's Social Sec #: Policyholder's Employer: Relationship to Patient:

PERSON RESPONSIBLE FOR PAYMENT: If patient is a minor, or is not the responsible party, complete the following:

Check if patient is responsible party RESPONSIBLE PARTY MUST BE OVER 18 YEARS OF AGE LAST FIRST MI

Mailing Address: STREET APT CITY STATE ZIP

Street Address: (IF DIFFERENT) STREET APT CITY STATE ZIP

Birthdate: / / Social Sec #: - - Driver's Lic #: _____

Home Phone: Work Phone: Cell Phone: _____

Employer Name: Employer Phone: _____

INJURY INFORMATION: If auto accident or other personal injury, please also complete MVA information form

My condition is related to: Work Auto Home Sports Other None/chronic

Date of injury/onset of condition: (Please give complete date) / /

Body side: Right Left Both N/A Body Part Affected: _____

CLAIMS MANAGER OR VOCATIONAL REHAB COUNSELOR NAME: (If Applicable)

Name: Phone: _____

Address: STREET CITY STATE ZIP

FINANCIAL INFORMATION

We'd like to thank you for choosing **NorthSound Physical Therapy** for your physical therapy needs. We feel strongly that our patients deserve the best possible care. In an effort to provide this, we would like to share information with you about financing healthcare. We hope that by providing you with this information, we can prevent misunderstandings and we hope that you will feel comfortable discussing financial and insurance matters with us.

All accounts not covered by insurance are due and payable in full at the time of service. We accept cash, credit cards and checks. If needed, you may arrange an extended payment plan with the billing department. Our fee schedule is available upon request.

REGARDING INSURANCE: As a courtesy to you, we will attempt to obtain and advise you of your physical therapy benefits. **This benefit quote to us by your insurance carrier is not a guarantee of payment nor representative of a contract between you and NorthSound Physical Therapy. Benefits will be determined when claims are processed and are subject to policy restrictions and limitations. We do not accept liability for denied or disputed claims.** Initials: _____

It is your responsibility to ensure that your treatment is properly authorized (if necessary), that you do not exceed your policy limits, and that treatment is fully reimbursed according to our financial policy.

We encourage you to contact your insurance carrier yourself to learn of specific limitations and restrictions to physical therapy under your plan. Any treatment denied by your insurance as being non-covered or exceeding your insurance limitations will become your financial responsibility. Initials: _____

Your copayment is due at the time of service. Your insurance policy is a contract between you and your insurance company. We are not a party to the contract between you and your insurance carrier, and cannot waive copays, coinsurance or deductibles. You are responsible for all account balances, even with insurance benefits.

Failure to pay your copay at the time of service may result in a \$5 fee per occurrence. This fee is not billable to your insurance. Initials: _____

If your personal balance becomes over 60 days past due, we reserve the right to assess a finance charge of up to 12% per year. Initials: _____

If your insurance policy has a large deductible or high coinsurance amount, you acknowledge that you have the financial ability to pay for your portion of your care in a timely manner. Initials: _____

This sheet is the full and final agreement between you and NSPT, Inc. regarding your insurance and benefits and may not be modified without a written agreement signed by you and this office. Initials: _____

LATE CANCELLATIONS AND NO-SHOWS: We understand that sometimes the unexpected can happen and you may be unable to keep an appointment. We would appreciate 24 hours notice prior to a scheduled appointment if you need to cancel or reschedule. If you fail to appear without contacting us for three scheduled appointments or cancel an excessive number of times, treatment may be discontinued and the referring physician(s) and claim manager notified.

I understand that if I no-show for my visit, or cancel with less than 4 business hours notice, I may be charged a fee of up to \$25 per visit. This fee is not billable to my insurance. Initials: _____

EMAIL:

- I understand that NorthSound Physical Therapy may email me from time to time. Emails may include newsletters, notices of special events, and billing inquiries. No private health information or financial information will be emailed. Initials: _____
- I would prefer that NorthSound Physical Therapy not email me. Initials: _____

AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I authorize my insurance benefits to be paid directly to NSPT, Inc. I also authorize the release of any information necessary for treatment, payment or healthcare operations. I understand that I am financially responsible for all charges for services rendered regardless of litigation, insurance reimbursement, or pending worker's compensation claims. I understand the parent or guardian accompanying a minor for treatment will be responsible for payment.

I acknowledge that I am financially responsible for any non-covered services, including treatment beyond my benefit limitations.

If patient is a minor, and in the event I cannot be reached in an emergency, I hereby give my permission to the physician selected by NorthSound Physical Therapy to administer emergency care.

I acknowledge that I have read and understand the financial policy and the no-show and cancellation policy stated above.

I certify that all information I have provided in this registration form is complete, true and correct to the best of my knowledge and I have provided NorthSound Physical Therapy with all insurance information for billing purposes.

Signature of Patient or Responsible Party

Date

Printed Name

MEDICARE PATIENTS ONLY

In Medicare-assigned claims, NSPT, Inc., agrees to accept charged determination of the Medicare carrier as the full charge. The patient is only responsible for the deductible, co-insurance and non-covered services. **In 2010, Medicare will not pay for physical therapy beyond the arbitrary financial limit of \$1860 regardless of extenuating circumstances.**

Signature of Medicare Patient

Date