NorthSound PHYSICAL THERAPY

*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 Phone: _____ Work Phone: _____ Ext: _____ Cell Phone: _____

Email Address (see reverse) _____

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)

How did you hear about NSPT? ❑ Doctor ❑ Ad ❑ Internet ❑ Friend/Family ❑ Community Event Prior patient of NSPT? ❑ Yes ❑ No

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

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

COMMUNICATION:

☐ **I would like to receive my billing statement electronically.** **Initials: _____**

☐ **I would like to receive a reminder prior to my appointment via : ☐ EMAIL ☐ TEXT ☐ PHONE CALL** **Initials: _____**

☐ **I would like to receive my home exercise program via email/text.** (Email address on front.)

I understand that NorthSound Physical Therapy may email me from time to time. Emails may include surveys, 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. (Do not give use your email address.) **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. I acknowledge that I have read and understand the financial policy and the no-show and cancellation policy stated above.

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 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. I confirm that if my condition is due to a worker's comp injury or motor vehicle accident, I have disclosed the claim information on this form.

_____ _____

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. Medicare only covers medically necessary treatment.

_____ _____

Signature of Medicare Patient **Date**