

# Patient Information Form

*We will bill your insurance for you, but it is your responsibility to give us the correct name and address of the insurance company.*

## Parent/Guardian Information (if patient is under 18 years old):

Name: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
Birthdate: \_\_\_\_\_ Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Other \_\_\_\_\_ Employer: \_\_\_\_\_  
Employer Telephone Number: \_\_\_\_\_

## Patient Information:

Legal Last Name: \_\_\_\_\_ Legal First Name: \_\_\_\_\_ MI: \_\_\_\_\_  
Address: (physical and mailing): \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Sex: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Other \_\_\_\_\_ Area to be treated: \_\_\_\_\_  
Patient's Employer: \_\_\_\_\_ Location: \_\_\_\_\_  
Name of physician who referred you to physical therapy? (First Name) \_\_\_\_\_ (Last Name) \_\_\_\_\_  
Name of primary care physician: (First Name) \_\_\_\_\_ (Last Name) \_\_\_\_\_  
Patient Email Address: \_\_\_\_\_

**For appointment reminders and information pertaining to TPTC. Information will not be shared with 3<sup>rd</sup> party solicitors.**

## Emergency Information: In case of emergency, notify the following people:

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone: \_\_\_\_\_  
2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Telephone: \_\_\_\_\_

## Insurance Information: (In addition to this information we will make a copy of your insurance card)

Name of Insurance Company: \_\_\_\_\_  
Date of Injury: \_\_\_\_\_ Accident: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes: Auto \_\_\_\_\_ Work \_\_\_\_\_ Other \_\_\_\_\_  
Workers Compensation Claim Number: \_\_\_\_\_ Employer: \_\_\_\_\_  
Address of Employer: \_\_\_\_\_  
Name of Policyholder: \_\_\_\_\_ Address: \_\_\_\_\_  
Policyholder's Employer: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Policyholder's Birthdate: \_\_\_\_\_  
Policyholder's Telephone: \_\_\_\_\_ Policy Group Number: \_\_\_\_\_  
Patient's Relationship to Policyholder: Self \_\_\_\_\_ Child \_\_\_\_\_ Spouse \_\_\_\_\_ Other \_\_\_\_\_  
Name of Secondary Policyholder: \_\_\_\_\_ Address: \_\_\_\_\_  
Secondary Policyholder's Employer: \_\_\_\_\_  
Social Security Number: \_\_\_\_\_ Secondary Policyholder's Birthdate: \_\_\_\_\_  
Secondary Policyholder's Telephone: \_\_\_\_\_ Policy Group Number: \_\_\_\_\_  
Patient's Relationship to Secondary Policyholder: Self \_\_\_\_\_ Child \_\_\_\_\_ Spouse \_\_\_\_\_ Other \_\_\_\_\_

# Financial Policy

**BILLING:** As a courtesy to our patient, TPTC will bill all primary and secondary insurance companies. Please provide us with complete and accurate insurance information, as well as any change of address, telephone number of employer.

**RESPONSIBILITY:** Your insurance coverage is a contract between you and your insurance company. You are responsible for payment of your account. If your deductible has not been met, full payment of your office visit is required. If your deductible has been met, you are required to pay the percentage not covered by your insurance carrier, or your co-pay upon arrival for all therapy visits. If you have a question regarding insurance payments, or the extent of services covered under your insurance plan, please contact your carrier regarding coverage.

**CHECK POLICY:** If you choose to pay by check and your check is dishonored, you agree to pay a service fee of \$25.00, or any higher amount allowed by law, and we may electronically debit or draft your account for this fee. Also, if your check is returned for insufficient or uncollected funds, your check may be electronically re-presented for payment.

**FINANCIAL DECISION:** Please indicate which payment method you will be using to meet your financial responsibility.

Cash  Check  Visa/MasterCard  Discover  American Express

I hereby consent to examination and treatment by Teays Physical Therapy Center, Inc. and authorize Teays Physical Therapy Center, Inc. to use or share my protected health information with the school athletic trainer or coach, and to obtain payment for my bills and to conduct its healthcare operations and business. I authorize payment to be made directly to Teays Physical Therapy Center, Inc., including Medicare, Medicaid or other benefits payable from any source, for all services rendered. I understand that I am ultimately responsible for payment of my account, and accept full responsibility for the cost of all services. I understand a 24-hour notice must be given when canceling an appointment or a charge may be added to my account. I realize that I have the right to refuse any procedure after having the risks and benefits explained to me.

SIGNATURE OF PATIENT/GUARDIAN: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_ DATE: \_\_\_\_\_