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: _____Email: _____
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) _____

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: _____
Name of Policyholder: _____
Address of Policyholder: _____
Policyholder's Employer: _____
Social Security Number: _____Policyholder's Birthdate: _____
Policyholder's Telephone: _____Policy Group Number: _____
Patient's Relationship to Policyholder: Self _____ Child _____ Spouse _____ Other _____

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

1. Name:_____ Relationship:_____ Telephone:_____
2. Name:_____ Relationship:_____ Telephone:_____

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:_____

(Revised 06/09)