advanced PHYSICAL THERAPY

Patient Information

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

Address: _____ City: _____ St_____ Zip_____

Home Phone: _____ Work: _____ Cell: _____ Birthdate: _____/_____/_____ Sex: M / F

Marital Status: Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑

Emergency Contact: _____ Telephone: _____

Doctor: _____ Telephone: _____

Date of last doctor's visit: _____

Employer: _____ Address: _____ City: _____ ST: _____ Zip: _____

Work title: _____

Work Status: Full ❑ Part time ❑ Retired ❑ Not Working ❑ Student: No ❑ Full time ❑ Part Time ❑

Policy Holder (if other than self) or Parent/Guardian

First Name: _____ MI _____ Last Name: _____ Date of Birth:____/____/____

Relationship to Patient: Spouse_____ Parent_____ Other_____ SS#:_____ Male: _____ Female _____

Address: _____ City, State, Zip: _____

Name of Spouses Employer: _____ Employed: FT ____ PT ____ Retired ____

Employers Address: _____ City, State, Zip: _____

PAYMENT IS EXPECTED AT TIME OF SERVICE

Policy Disclosures

As a courtesy, we will bill your insurance company for applicable rehabilitation services performed. We also offer select rehabilitation products (typically used at home or work) for purchase. Please note we do not bill insurance for these products. Co-pays and/or deductibles are due at the time services are rendered. The patient is ultimately responsible for any balance that is not paid by insurance. Initial _____

Please provide us with at least twenty-four hours notice should you need to reschedule or cancel an appointment otherwise you may be billed your co-pay or a charge of $40.00, whichever is greater. Patients that arrive fifteen minutes or more late may be asked to reschedule their appointment. Initial _____

A storage area is available to our patients during their visit. We are not able to accept liability for any personal items brought to the Center. We are a smoke and drug free environment. Initial _____

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Consent for Treatment and Benefits

My signature is required below to authorize treatment. My signature also authorizes the release of my medical information (including but not limited to my physician, insurance company, employer, school, related healthcare provider, nurse case manager, attorney, assignees, beneficiaries, and all other related persons to my treatment) that is needed to process my claim. I also agree to a direct assignment of my benefits to Michael Martines Physical Therapist, INC., d/b/a Advanced Physical Therapy where a claim has been filed, the payment of medical benefits directly to this practice for services rendered, and to comply with the above policies. We reserve the right to change our policies without prior notice.
I am aware of my diagnosis and voluntarily consent to treatment at this practice. No guarantees have been made to me about the outcome of care provided at this practice. I agree to the services rendered and to cooperate in providing information necessary to process my claims(s) with third party-payers. Where the law or my insurance contract does not prohibit payment by me, I accept responsibility to pay any and all of my account balances (even if the balance differs from the benefit verification form as it is not a guarantee for coverage). A photo copy of this agreement shall be as effective and valid as the original. All information provided on this document is accurate to the best of my knowledge.

Patient Signature: _____ **Date: _____**

Patient/Guardian's Signature: _____ Date: _____

Authorization for the Release of Medical Record Information

I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and healthcare operations. I also grant permission for this practice and its affiliates to obtain information from my physician and other medical professionals as it relates to my treatment.

Patient Signature: _____ **Date: _____**

Patient/Guardian's Signature: _____ Date: _____

BENEFIT DISCLAIMER

It is the patient/insured person's sole responsibility to know their outpatient physical therapy benefits. Advanced Physical Therapy is not required to contact your insurance company but does so as a courtesy.

Advanced Physical Therapy may contact your insurance company prior to your initial visit to verify coverage. The information received is not a guarantee of payment. Patients are expected to know their plan benefits and limitations prior to their initial visit.

Advanced Physical Therapy is bound contractually to accept negotiated rates with contracted insurance carriers and all co-pays, Co-insurance and deductibles are to be paid at time of service.

If a payment plan is needed please discuss with the front office prior to treatment.

Advanced Physical Therapy accepts MasterCard, Visa, Discover, checks, cash, and debit cards.

Patient/Guardian Signature: _____ Date: _____