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:_____

Home Phone:_____ Business Phone:_____ Cell Phone: _____

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 or Guardian Email Address:_____

For appointment reminders and information pertaining to TPTC. Information will not be shared with 3rd 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 $50.00 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:_____