Four Pines Physical Therapy, PC

Patient Information Sheet

Last Name_____ First Name_____ MI_____SSN_____

Mailing Address_____City_____ST_____ZIP_____

Home Phone_____ Cell Phone _____ Work_____

Date of Birth_____ Gender___ Email_____

Appointment reminders (choose one) by: Voice____ Email____ Text _____

Current Employer_____ Phone_____

Address_____City_____ST_____Zip_____

Emergency Contact

Name_____ Phone_____ Relation_____

Problem Description_____ Date of Injury_____

Referred by_____ Primary Dr. _____ Phone_____

Primary Insurance_____ Subscriber_____

Relationship to insured _____ Date of Birth_____

Secondary/Supplemental Insurance_____ Subscriber _____

Relationship to insured _____ Date of Birth_____

Have you received physical therapy treatment within the last year (please circle): Yes / No

IF Worker's Comp (check here) _____ **IF motor vehicle accident** (check here) _____

Current Medications – please list all medications (prescriptions, over the counter medications, herbals, vitamins, minerals and dietary supplements). Include dosage, frequency, purpose, and administration method.

Medication	Dosage	Purpose	Frequency	Method of Administration

___ I am not taking any medications, vitamins or supplements not on this list at this time. See attached list _____

Payment/Insurance Policy

For your convenience, we will bill all insurance companies. Complete and accurate insurance information plus a copy of your card must be provided at time of service. We suggest you contact your insurance to know your coverage. Any non-covered services are your responsibility and payment is required at time of service. We will accept payment directly from your insurance company with the following provisions:

1. Patient agrees to provide insurance information to Four Pines Physical Therapy's physical therapists and staff.
2. Patient authorizes notice to the insurance company of assignment below.
3. If your insurance company pays you directly, you have 10 days to provide us with the explanation of benefits and the amount paid by the Insurance.

In the absence/cancellation/denial by the insurance company, the patient is responsible for the account. Unpaid accounts **90** days past due will be sent to an outside COLLECTIONS company. In addition to unpaid portion of account, the patient is responsible for collection fees and interest charges on the past due account. **Initial_____**

Accounts must be paid within **6 months** of insurance processing. **Initial_____**

A late fee of $25 per month will be added to your unpaid balance that is 60 days or more overdue. The total balance may be paid in full at any time without penalty or additional finance charge**.** **Initial_____**

I give permission to this office, it's service providers, collection agencies, successors and assigns to email/dial/text/leave a message on any phone/voicemail/email address of any phone (home and cell phones)and emails provided by or otherwise owned by me or my spouse which may be include the name of company dialing the call, regarding services provided and my financial obligations regarding those services. **Initial_____**

Appointment Cancellation Policy: We require a minimum of 24 hrs advanced notice of cancellation of a scheduled appointment. A $**45.00** fee will be charged for **No Show** or **Cancellation** less than 24-hour notice.
Emergencies that require canceling a scheduled appointment will be handled on a case by case basis. **Initial_____**

Notice Regarding Insurance Company Assignment

In the event my insurance company makes payment for services provided by Four Pines directly to me, I agree to immediately remit all such payments to Four Pines to be applied to my account balance. I acknowledge that all unpaid balances are my responsibility as noted above. I hereby authorize the insurance company to provide the clinic with any information regarding the processing and payment of my insurance claim.

I have read and understand the Financial Policy for Four Pines Physical Therapy, PC. I understand that I am responsible for any balance due. Accounts with balance will be subject to interest rate of 1.75% after 90 days.
I authorize treatment by the Staff of Four Pines Physical Therapy, PC
I authorize payment of medical benefits to undersigned provider or supplier for these services and all future claims.
I authorize the release of any medical information necessary to process this claim and all future claims.
I authorize release of information to my referring physicians and lawyer if needed for MVA
I agree to comply with the terms and conditions as outlined on the Patient Registration form.
I hereby acknowledge that I have received a copy of the Notice of Health Insurance Privacy Policies Act.

Patient/Guarantor_____ **Date**_____

Rev: 9/2019