

North Pole Physical Therapy Patient Information

PATIENTS NAME: _____ PHONE: _____
SS#: _____ BIRTHDAY: _____ AGE: _____ M F HT _____ WT _____

MAILING ADDRESS:

JOB TITLE _____ YEARS AT JOB _____

CURRENT EMPLOYER: _____

ADDRESS: _____ PHONE: _____

EMERGENCY CONTACT (NAME) _____ PHONE _____

INJURY DATE/DATE OF ONSET: _____ REFERRED BY WHICH DOCTOR: _____

INJURY WAS/IS (check one): EMPLOYMENT RELATED AUTO ACCIDENT OTHER

Please list any person(s) you wish to authorize to speak with NPPT in regards to your account per HIPAA guidelines.

NORTH POLE PHYSICAL THERAPY POLICIES

Our fees: We use the fee guide published annually by MAG mutual Healthcare Solutions, Inc.
Payment: We accept cash, checks or credit cards. You will be sent a monthly statement. Your balance is due in 30 days.
No Show: If you fail to cancel your appointment **24 hours** in advance, you may be billed a **\$15.00 no show fee** which cannot be billed to your insurance. If you miss more than **three** appointments you may be seen on a walk-in basis only.
Pool Policy: Because pool appointments are seen away from the clinic, missed appointments limit our ability to provide therapy to all our patients. If two pool appointments are missed, you will be seen in the clinic only.
_____ (**Patient Initials**)

Consent for Physical Therapy

I consent to physical therapy evaluation and treatment provided by North Pole Physical Therapy. Physical therapy includes tests and treatment ordered by my physician or deemed necessary by the physical therapist. The practice of medicine is not an exact science. No guarantees have been made to me about the results of tests or treatment.

I am aware that I may experience soreness and possibly pain with physical therapy testing and treatment. The therapist will do all to ensure my comfort. I realize that it is my responsibility to inform my therapist of any soreness or pain I experience during therapy sessions or during a home exercise program.

I have received the HIPAA Notice of Privacy Practices from North Pole Physical Therapy.

I have read this consent for physical therapy and agree to its terms.

Signature

Date

Signature

Date

NORTH POLE PHYSICAL THERAPY INSURANCE POLICIES

	PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Co.		
Address		
Name of Policy Holder		
ID Number		
Plan/Group Number		
Member's Date of Birth		
WC Adjuster (If applicable)		

Insurance: Remember that you are ultimately responsible for your bill.

- **Private** If you have private insurance, as a courtesy we will bill your primary and secondary carriers for our services. If your insurance pays and there is still an outstanding balance, you will be billed. Remember that insurance is a contract between you and your insurer. We will be happy to help as we can send records, but will not become involved in disputes concerning deductibles, co-payments, secondary insurance, or so-called "usual and customary" reductions.
- **Medicare** Remember that you do have a co-payment and a deductible and we request that you pay this once a month with your monthly statement.
- **Veteran's Administration** Patients are required to get pre-authorization before your first visit if you would like the VA to pay. Our staff can assist you with further authorizations if you wish.
- **Workman's Compensation** If you would like us to bill your workman's compensation company, you will need to provide us with the claim number, name, address, phone number, and your claim adjuster's name. We will not become involved in disputes concerning authorization and or payment, and you are personally responsible for payment in the event that your benefits are denied.
- **Auto/Personal Injury** If you wish us to bill an auto insurance company you will need to provide us with the name, address, phone number, and a claim number. We will not become involved in disputes concerning maximum benefits, responsibility, or authorizations. *If your insurance has not paid in 90 days, we expect you to start making payments on your account.*

Patient's Agreement: I understand that it is not the responsibility of my insurance company to pay any bills accrued, but that it is my responsibility to pay all bills. In consideration of this, I agree to pay all bills that have not been paid by the insurance company **within 90 days** unless a monthly installment plan has been arranged and approved. I hereby authorize payment to be made directly to North Pole Physical Therapy for services rendered. I further authorize the release of medical records to my insurance company, Social Security Administration, its intermediaries or carriers in order to assist in reimbursement.

Signature

Printed Name

Date

North Pole Physical Therapy

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