North Pole Physical Therapy Patient Information

PATIENT NAME: _____ CELL: _____ PHONE_____

SS#: _____ BIRTHDAY: ____/____/____. AGE: _____ M / F

MAILING ADRESS: _____

_____

EMAIL: _____ **HOW DID YOU HEAR ABOUT US?** _____

JOB TITLE _____ YEARS AT JOB _____

CURRENT EMPLOYER: _____ PHONE: _____

ADDRESS: _____

EMERGENCY CONTACT (NAME)_____PHONE_____

RESPONSIBLE PARTY (PARENT/GUARDIAN SIGNING PAPERWORK) DOB: _____

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

_____

Insurance Carrier	PRIM:	SEC:
Name of Policy Holder		
ID Number/SS# if Military		
Plan/Group Number		
Policy Holder's Date of Birth		
WC Adjuster Name/Number		

OUT PT/REHAB BENEFITS:

Date/Whom spoke with: _____

Effective date: _____ Deductible: _____Met? _____

% paid after deductible: _____ Out of pocket max:_____

Limit on # of appts: _____Script Req: _____ Pre-Auth Req: _____

Patient notified of benefits: _____

Workers Comp Claim#: _____
Claims Address: _____
Body part: _____ Open and billable: YES ____ NO ____

I have reviewed and added/made any corrections to the above information. I have had the opportunity to ask any questions regarding the above information.

Signature_____ Date: _____

NORTH POLE PHYSICAL THERAPY POLICIES

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

_____ _____

Signature Date

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 by cancels OR no shows you may be placed on a same day call-in basis.**

_____ (**Patient/Responsible Party Initials)**

Remember 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**. COPAYS ARE DUE EACH VISIT. DEDUCTIBLES AND CO-INSURANCE ARE DUE FOLLOWING EACH VISIT OR WEEKLY UNLESS ARRANGEMENTS HAVE BEEN MADE PRIOR TO SERVICES BEING RENENDERED.**
- **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 your 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 60 days, you are expected to start making payments on your account.***
- **Tricare Prime** patients are required to obtain an authorization prior to services unless secondary. **There is a $12.00 copay for retiree policies due at time of service or weekly.** In the event you would choose to be seen without an authorization you will be responsible for cost-share amounts.
- **Our fees**: We use the fee guide published annually by MAG Mutual Healthcare Solutions, Inc.

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

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 60 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