WELCOME TO OUR PRACTICE . . .
Physical Sports Therapy

DATE: _____

Account #_____

RESPONSIBLE PARTY INFORMATION (if different from patient)

MARITAL STATUS: MARRIED SINGLE DIVORCED WIDOWED

NAME: RELATIONSHIP TO PATIENT- SPOUSE – FATHER – MOTHER – SELF - OTHER

MAILING ADDRESS: APT# CITY STATE ZIP

PHONE: ( ) DATE OF BIRTH / / AGE SEX: M F SOCIAL SECURITY NO. - -
(MO)(DAY)(YEAR)

EMPLOYER: EMPLOYER PHONE: ( )

(if self employed, please list business)

PATIENT INFORMATION E-MAIL ADDRESS:_____

NAME: PREFERRED NAME:

MAILING ADDRESS: APT# CITY STATE ZIP

STREET ADDRESS: APT# CITY STATE ZIP

MARRIED SINGLE

PHONE: ( ) DATE OF BIRTH / / AGE SEX: M F MARITAL STATUS: DIVORCED WIDOWED

SOCIAL SEC. NO. - - EMPOYER: PHONE: ( )

REFERRING PHYSICIAN: WHOM CAN WE THANK FOR REFERRING YOU TO US:

REASON FOR VISIT

ACCIDENT/INJURY INFORMATION

DATE: BRIEF DESCRIPTION:

IS INJURY RELATED TO: ACCIDENT? Y / N AUTO? Y / N WORK? Y / N

EMERGENCY CONTACT: **PHONE:**

INSURANCE INFORMATION

1) PRIMARY INSURANCE COMPANY: _____

CLAIMS ADDRESS CITY STATE ZIP

ID NO. GROUP NO.

RELATIONSHIP OF PATIENT TO INSURED (CIRCLE ONE) SELF SPOUSE CHILD OTHER (LIST)

POLICY HOLDER: DATE OF BIRTH / / AGE

EMPLOYED WITH:

2) SECONDARY INSURANCE COMPANY: _____

CLAIMS ADDRESS CITY STATE ZIP

ID NO. GROUP NO.

RELATIONSHIP OF PATIENT TO INSURED (CIRCLE ONE) SELF SPOUSE CHILD OTHER (LIST)

POLICY HOLDER: DATE OF BIRTH / / AGE

EMPLOYED WITH:

Physical Sports Therapy

ASSIGNMENT OF BENEFITS / MEDICAL RELEASE / CONSENT FOR TREATMENT

With this form I acknowledge I have been provided a copy of the NOTICE OF PRIVACY from PHYSICAL SPORTS THERAPY and authorize the release and disclosure of portions of my medical record necessary to obtain reimbursement for myself and for my covered dependents. This authorization gives PHYSICAL SPORTS THERAPY the right to request and receive medical information from other health care entities and providers to include but not limited to copies of diagnostic test reports, surgical reports, and other clinic information deemed necessary by PHYSICAL SPORTS THERAPY therapists or representatives. I understand I am not required to sign this authorization as a condition of my treatment, unless permitted by law. I also understand that I may inspect my protected health information, request more information, and revoke this authorization, as permitted by the federal privacy regulations and in accordance with PHYSICAL SPORTS THERAPY privacy policy.

INSURED'S SIGNATURE: _____ DATE: _____

I hereby consent to any therapy treatment, or other procedure, which the therapist(s) may consider or advise in treatment of my case (or as legal guardian for patient). I hereby authorize any benefits due me to be paid directly to PHYSICAL & SPORTS THERAPY SERVICES, 380 East 400 South, Springville, UT 84663. This agreement will remain in effect until I choose to revoke it in writing.

INSURED'S SIGNATURE: _____ DATE: _____

CREDIT AND FINANCE CHARGE POLICY AND AGREEMENT

By signing below I agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. I understand that the benefits given to Physical Sports Therapy by my insurance company are just an estimate and not a guarantee of payment and that payment will be determined once the claims are processed. However, regardless of insurance coverage, I understand and agree that I am financially responsible for all deductible amounts, co-insurance, co-payments, non-covered services or services deemed as "non-medically necessary" by my third party insurance carrier(s). I agree that interest will accrue on all past-due amounts at the rate of 1.5% per month until paid in full. In the event any amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 40% of the principle amount(s) owing as allowed by Utah Code Annotated, sec. 12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.

INSURED'S SIGNATURE: _____ DATE: _____

EMPLOYEE SIGNATURE: _____ DATE: _____

MEDICARE PATIENT AGREEMENT
(Required by Medicare for all Medicare claims)

_____ - _____ - _____

ENTITLEE'S NAME MEDICARE SUBSCRIBER NUMBER

Request that payment of authorized Medicare benefits be made either to me or on my behalf to PHYSICAL SPORTS THERAPY for any services furnished by that provider. I authorize any holder of medical information about me to release to Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits for related services.

This authorization is in effect until I choose to revoke it in writing.

SIGNATURE: _____ DATE: _____

NOTICE TO MEDICARE PATIENTS:

EFFECTIVE JANUARY 1, 2006 MEDICARE IMPLEMENTED OUTPATIENT THERAPY CAPS. THE CAP FOR 2010 IS $1860 PER YEAR. THIS CAP AFFECTS ALL MEDICARE PATIENTS, WITH ONLY A FEW EXCEPTIONS. ANY TREATMENT RECEIVED IN EXCESS OF THE ALLOWED AMOUNT IS THE RESPONSIBILITY OF THE PATIENT. IF YOU HAVE RECEIVED ANY PHYSICAL THERAPY SERVICES, INCLUDING HOME HEALTH, AT ANY OTHER CLINIC SINCE JANUARY 1 OF THE CURRENT YEAR PLEASE LET US KNOW.