PATIENT INFORMATION

First Name: ______________________ Last Name: ______________________ MI: ________ DOB: ____/____/_____

Parent/Guardian: ____
NAME Relationship Phone#

Address: ______________________________ City: ______________________ State: _____ Zip: _________

Home Phone: (_____) ________________ Cell Phone: (______) ______________________

Email: ______________________________ Gender: ☐ Male ☐ Female SSN: _______/______/_________

Emergency Contact: ____
NAME Relationship Phone#

EMPLOYER

Name: ______________________________________ Phone: (_______)________________

Address: ______________________________________ City: ____________________ State: _______ Zip:_________

CLAIM INFORMATION (If Applicable)

☐ Worker's Comp ☐ Motor Vehicle Accident Claim #: ________________________ Date of Injury: ____/____/_____

Insurance Company:_________________________ Adjuster/Claim Manager's Name: ______________________________

Mailing Address:______________________________ Phone: (_____) ______________ Fax: (_____)______________

☐ Billed to my health insurance
I agree to pay all applicable co-payments associated with the charges the day of service. I have contacted my health insurance carrier and they have authorized billing them for these services. I understand that if my health insurance denies this claim, I am responsible to pay the charges in full.

☐ Billed to me directly
I understand that Summit Health Physical therapy does not wait for settlements from third parties, including attorneys. I can ask to receive a billing statement that I can turn in for reimbursement, if needed, from a third party.

☐ Billed to my auto insurance/WCOMP
I authorize the release of my medical records, related to my accident, to the company listed which is required for payment. I understand that if my auto insurance/WCOMP denies this claim or does not pay in a timely amount of time, I am responsible to pay the charges in full.

Consent for Care & Treatment

I, the undersigned, do hereby agree and give my consent for Summit Health Physical Therapy to furnish medical care and treatment considered necessary and proper in diagnosing and treating of me or my child's physical condition. Patients 18 years and younger must be accompanied by a guardian.

Notice of Privacy Practices

The policies and procedures of Summit Health Physical Therapy are designed to comply with the Health Insurance Portability and Accountability Act (HIPAA). I agree that the Privacy Notice of Summit Health Physical Therapy has been made available to me.

Benefit Assignment & Release of Information

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payers to Summit Health Physical Therapy. I hereby authorize said assignee to release all information necessary, including medical records, to secure payment.

Financial Policy Statement

Summit Health Physical Therapy will try to provide a general overview of physical therapy benefits as a courtesy, and is not responsible for any discrepancy between the information provided to us and what the patient's actual benefits may be.

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered services.
- Co-payments are due at the time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at the time of service.

The undersigned patient or patient's guardian hereby acknowledges have reading, understanding, and agrees to the conditions set forth in the Authorization to Treat, the Notice of Privacy Practices, Assignment of Insurance Benefits, and Financial Policy agreement.

Patient Name Printed: ____ Date ____ / ____ / ____

Patient/Guardian Signature: ______________________________________ Date ____ / ____ / ____
(18 and older)