Andrew Physical Therapy

ORTHOPEDIC & SPORTS REHAB

Date _____

Prior Patient? Yes / No

How did you hear about us? _____
(physician, friend, other)

Name _____ Date of Birth ____/____/____
Last First MI

Mailing Address _____ City _____ ST ____ Zip _____

Home Phone _____ Cell Phone _____ Email Address _____

Text, Call or Email with Reminders (Please Underline One)

Male/Female (Circle One) SS# ____-____-____ Married/Single (Circle One) Emergency Contact _____

Phone _____

Referring Physician _____ Primary Care Physician _____

Name of your Employer _____ Phone # _____

Primary Insurance _____ ID # _____ Group # _____

Policy Holder _____ Date of Birth ____/____/____

Secondary Insurance _____ ID# _____ Group # _____

Policy Holder _____ Date of Birth ____/____/____

If this visit a result of a work or auto accident fill in section below

Name of Worker's Comp or MV Company _____ Date of Accident ____/____/____

Claim# _____ Adjusters Name _____ Phone _____

No Show & Cancellation Policy

Please note that any patient arriving more than 10 minutes late to their scheduled appointment may be rescheduled in order to accommodate the needs of those who have arrived on time for their scheduled appointments. Cancellations must occur prior to 24 hours of the appointment so it can be given to someone else in need in. Cancellations with less than 24 hours notice, the patient will automatically incur a $40 fee.

Assignment of Insurance Benefits & Agreement to Pay

The undersigned does hereby agree and give consent for Andrew Physical Therapy to furnish medical care and treatment considered necessary & proper in treatment of this physical condition. Please understand that your insurance plan is between you and your insurance company; therefore, Andrew Physical Therapy PC, will not become involved in any disputes you encounter with your coverage or become engaged in litigation with your insurance company.

You are fully responsible for any amounts not paid by your insurance. The undersigned agrees that should the amount be insufficient to cover the entire expense for physical therapy services, the insured will be responsible for the payment of the difference, including any co-pays or deductibles. If for any reason your insurance company does not cover services you received within (60) sixty days, the full amount billed will become your responsibility to pay immediately. It is your responsibility to provide us with your insurance information prior to receiving services. Verification of benefits is not a guarantee of payment and you will be responsible for any services considered non-covered by your insurance. A **$25** fee is charged for any returned checks or stop payments initiated by the patient.

I hereby authorize release of my Physical Therapy Medical Records and Billing Statements to my Insurance Company and/or my Attorney if applicable. I have read, understand and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable out of pocket expenses, are my responsibility.

Date _____ **Client/Guardian Signature** _____