Harbor Physical Therapy Patient Information Form

DEMOGRAPHICS **MUST COMPLETE ALL INFORMATION**

Date _____ Date of Birth _____ Social Security Number _____

First Name _____ MI _____ Last Name _____ Height _____ Weight _____

Street/P.O. Box Address _____ City _____ State _____ ZIP _____

Home Phone Number _____ Cell Phone Number _____ Email _____

APPOINTMENT REMINDER: ___Call Home# ___Call Cell# ___Text Cell# ___No Reminder

HOW DID YOU HEAR ABOUT US? ☐ **Facebook/Social Media** ☐ Friend ☐ Doctor ☐ Web Search

Employed / Unemployed / Retired _____
Employer / Occupation / Work Number

Emergency Contact Name, Relationship, Phone Number _____ Parent/Guardian (if under the age of 18) _____

INJURY/BODY PART INFORMATION

For which body part are you being seen today? _____

Date of injury OR approximate date that symptoms started? _____

Surgery: ___**YES** ___**NO** Date of surgery/name of surgeon: _____

Have you ever had an EMG, Angiograph, Ultrasound, MRI, CAT scan, or X-rays of your injured areas? If so, when and where? _____

Which Physician referred you to Physical Therapy? _____

Who is your Primary Care Physician (PCP)? _____

Is this condition related to (circle one): Employment Auto Accident Other _____

INSURANCE INFORMATION: WE MUST HAVE THIS ON PAPER TOO.

Primary Insurance Company _____ Member ID Number _____ Group Number _____

Subscriber Name: (Self, Spouse, Parent, Other) _____ Subscriber's SSN _____ Subscriber's Date of Birth _____

Secondary Insurance Company _____ Member ID Number _____ Group Number _____

Subscriber Name: (Self, Spouse, Parent, Other) _____ Subscriber's SSN _____ Subscriber's Date of Birth _____

HARBOR PHYSICAL THERAPY
CONDITIONS OF BILLING

PLEASE READ CAREFULLY AND SIGN BELOW WHERE INDICATED

1. **Assignment of insurance benefits**: I hereby assign all appropriate benefits and proceeds to Harbor Physical Therapy for application on my bill; I understand that any portions of my treatment not covered by insurance, including co-pays, are my responsibility.

2. **Financial Agreement**: I promise to promptly pay for services rendered to me. Balances over 60 days will begin to accrue 1.4% interest. Should this account be turned over to collections, I understand that I shall be responsible for any additional fees and/or collection expenses.

3. **Outside Services**: I understand that I may be billed separately for services such as equipment supply and/or rental that are not included in the regular cost of therapy.

SIGNED: _____ DATE: _____

*****CANCELLATION & NO-SHOW POLICY*****

You will be charged $25 for missed appointments and/or cancellations made without 24 hours prior notice. However, you will not be charged if you are able to reschedule your treatment during an existing opening on the same day.

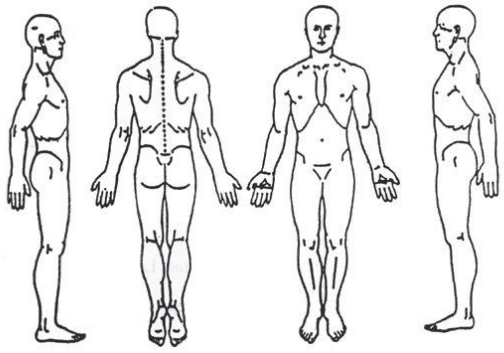
FOR MEDICARE PATIENTS ONLY

I certify that information given by me in applying for payment under the appropriate laws of the social security act of HB 89-97 is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf. I assign payment of the unpaid charges of the therapists for whom Harbor Physical Therapy is authorized to bill in connection with its services. I understand that I am responsible for any health insurance deductibles and 20% of the remaining reasonable charges. I request that this authorization apply throughout the period of treatment.

SIGNED: _____ DATE: _____

MEDICARE PATIENTS: If you are a Medicare patient, your PCP must certify physical therapy every 10th visit and every 30 days after your initial visit. Your PCP may require that you see him/her for a re-evaluation to certify continued therapy. **Initial**: _____

On the diagram, please mark the location of your symptoms... (pain, muscle tightness, tension, stiffness, swelling, spasm, etc)



Height: _____
Weight: _____
BMI: _____

Name_____ **File#** _____

R5/99:kjb