HARBOR PHYSICAL THERAPY

Recover Faster. Work Better. Play Harder.

DEMOGRAPHICS

Today's Date: _________

First name MI Last name

Date of Birth

Street/PO Box City State ZIP

Cell Phone Number Email Home Phone Number

APPOINTMENT REMINDER PREFERENCE: ☐ TEXT CELL ☐ CALL CELL ☐ CALL HOME ☐ Opt Out

How did you hear about us?: ☐ Referral ☐ Web search ☐ Social Media ☐ Friend ☐ Other

Emergency Contact Name/Relationship/Phone Number: Parent/Guardian (if under age 18):

Are you: ☐ Employed ☐ Unemployed ☐ Retired ____

Employer / Occupation / Work Number:

Which Physician referred you to Physical Therapy?: ____

Who is your Primary Care Physician (PCP)?: ____

This condition is related to: ☐ Work ☐ Auto ☐ Other: ____ ☐ N/A

Have you had an EMG, ANGIOGRAPH, ULTRASOUND, MRI, CAT SCAN, OR X-RAYS done on your injured areas? If yes, when & where?

Date: ___________________________________ From: _______________________________________

INSURANCE INFORMATION (IN ADDITION TO DIGITAL RECORDS)

PRIMARY Insurance Member ID Group Number

Subscriber Name Relationship to Subscriber (Self, Spouse, Other) Subscriber DOB or SSN

SECONDARY Insurance Member ID Group Number

Subscriber Name Relationship to Subscriber (Self, Spouse, Other) Subscriber DOB or SSN

CONDITIONS OF BILLING:

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, co-insurance, deductibles, and non-covered services are my responsibility. It is my responsibility to contact my insurance plan to confirm that these services are covered.
2. **FINANCIAL AGREEMENT:** I agree to promptly pay for services rendered to me. Balances over 60 days will be subject to Collections. 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 rentals that are not included in the regular cost of therapy (including but not limited to kinesio tape, theraband, theratube, pulleys,etc).

SIGNED: ____ DATE: ______________________

LATE CANCELLATION AND NO SHOW POLICY (effective July 2022):

The patient is responsible for remembering their scheduled appointment. Our staff can provide a print out of your upcoming appointments upon request. You may receive email, text, or phone call reminders 48 hours prior to your appointment. Please be considerate and provide adequate notice if you cannot make it. When you cancel late, we are unable to give that appointment to someone else who needs our assistance. We require a minimum of **48 BUSINESS HOURS NOTICE** to **change or cancel** your appointment. If a patient is late to their appointment, the scheduled 1 hour appointment with the therapist will not be fully serviced due to the time limitation. Physical therapists are paid by insurance for time spent treating patients; insurance does not pay for missed appointments or late arrivals. You will be charged a **$65 fee** for any changes or cancellations made within the 48 business hours.

If you **No Show** your scheduled appointment, you will be charged with a **$165 fee**, the cost of an out-of-pocket visit, to be paid in full prior to your next appointment. If we do not receive communication from you within 24 hours of the skipped appointment, we will assume that you do not wish to return to HPT, and all further appointments will be canceled. We reserve the right to move you to same-day appointments after 3 cancellations. We understand that emergencies happen; please communicate with us ASAP and we will try our best to accommodate you.

SIGNED: ____ DATE: ______________________

FOR MEDICARE PATIENTS ONLY:

I certify that information given to me in applying for payment under the appropriate laws of the social security act of HB 89-97 is correct. I authorize the 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/or every 90 days after your initial visit. Your PCP may require that you see them for a re-evaluation to certify continued therapy.

Initial: ___________