Patient Information

First Name:______________________ MI: ______ Last Name:____

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

Birthdate:____/____/____ Day Phone:____________ Evening Phone:_____________ Cell Phone:_______________

Gender (circle): M / F Social Security #:_________________ (Use signing parent's # if patient is minor under 19 yrs)

Email Address:________________________________ Can we email appointment reminders & information? Yes / No

Emergency Contact:________________________________ Relationship:____________________________________

Home Phone:____________________ Work Phone:______________________ Cell Phone:_____________________

Primary Insurance Information

Have you attended Physical Therapy or Speech Therapy for this or another condition during this year? Yes / No

If so, please note when ____/____/____ and the number of visits utilized______.

If your primary insurance is Medicare, you may not be treated here if you are receiving ANY type of Home Care. **If you are receiving ANY type of Home Care treatment, you will be personally responsible for our charges!!**

Insurance Company Name:___________________________________ Address:________________________________

City:__________________________________ State:______ Zip:___________ Phone#:______________________

ID#:_____________________ Group#:________________________ Name of Insured Person:___________________

Relation:_______________________ Birthdate:____/____/____ Insured Employer:__________________________

Employer Address:____

Secondary Insurance Information

Insurance Company Name:___________________________________ Address:________________________________

City:__________________________________ State:______ Zip:___________ Phone#:______________________

ID#:_____________________ Group#:________________________ Name of Insured Person:___________________

Relation:_______________________ Birthdate:____/____/____ Insured Employer:__________________________

Employer Address:____

I give my permission to SportsFocus Physical Therapy, PC to Release information to my insurance company. I authorize payment directly to SportsFocus Physical Therapy, PC for treatment I receive.

Signature:____ Date: ____/____/____
(Signature of Patient or Guardian if patient is under 19)

I agree I am primarily liable for all charges for services rendered by SportsFocus Physical Therapy, PC and agree to pay all amounts not paid by my insurance carrier(s) for any reason. If I make payment to SportsFocus Physical Therapy, PC in cash I understand that I must obtain a receipt for and retain this receipt for a least 3 months. I understand in the event amounts are not paid when due, I agree to pay all reasonable attorney's fees and collection costs you may incur to collect such past due amounts. If referred to collection, a fee of 33.33% of your outstanding balance over $100 will be added to your account. For amounts less than $100, 40% of the balance will be added to your account. If a second statement is required, a $5.00 billing fee will be added to your account. CO-PAYS ARE DUE AT THE TIME OF EACH VISIT.

Signature:____ Date: ____/____/____
(Signature of Patient or Guardian if patient is under 19)

I have been advised of SportsFocus Physical Therapy's Notice of Privacy Practices Regarding Patient Health Information. You may request a copy of this at any time.

Signature:____ Date: ____/____/____
(Signature of Patient or Guardian if patient is under 19)

HMO Plans

All HMO policies have a set coverage limit (i.e. 20 visits or 2 months, etc.). You should determine the amount of coverage available by contacting your insurance company. Treatment beyond your coverage limits will be your responsibility. It is important to let us know if you have had any previous physical therapy treatment at any other clinic in your contract year as that may shorten your benefit. Almost all HMO policies require a co-payment. These are due at time of treatment.

High Deductible HMO plans

These plans require that your deductible is met before covering services. If your deductible has not been met, you will be responsible for 100% of allowed charges until your deductible has been reached. After your deductible has been met, there is typically a co-pay that will be required each visit. We will bill your insurance company and you will receive a bill and be responsible for the remaining balance.

Medicare

Medicare will NOT pay for our services if you are under any type of home health care. Medicare has instituted a "cap" on the amount of therapy they will pay for. The cap for 2012 is $1880. We will monitor the charges and try and alert you if we approach the limit. If you are receiving Speech therapy, this will also go toward the Medicare allowance. Medicare also has a deductible for all medical care that must be met before it will begin covering 80% of allowed charges. You will be billed and responsible for the remaining 20%. If you have a secondary insurance, as a courtesy, we will bill your secondary insurance company. After receiving payment from the secondary insurance, you will receive a bill and be responsible for the remaining balance.

Medicaid and Fidelis

We are not approved providers for Medicaid and Fedelis, therefore treatment will not be covered by this insurance.

Blue Cross Major Medical

Blue Cross almost always has a 20% co-insurance feature. This 20% is due a time of treatment. This will typically be $21.00 for the initial visit and $9.00 for subsequent visits.

Empire Plan Insurance (Managed Physical Network)

We are participating providers and the copay is typically $20.00, which is due a time of treatment.

Aetna, United Healthcare and others

Plans from various other carriers may be a major medical or HMO type policy. While we will see patients with all types of insurance, we are not "participating providers", do not accept insurance and are often considered "out of network" providers. YOU MUST check with your insurance on how much, if any, they will cover. Most of these plans will have deductibles that must be met, before it will begin to cover medical care. After billing your insurance company, you will be billed and responsible for the percentage not covered by insurance.

Signature:____ Date: ____/____/____
(Signature of Patient or Guardian if patient is under 19)

Cancellation/No-Show Policy

We request that you call as soon as possible if you are unable to make a scheduled appointment. However we understand that there are many legitimate and unforeseeable reasons for being unable to attend a scheduled visit. We will allow a total of 3 cancellations or no-shows during your physical therapy care before charging $25 for each future cancellation or no-show.

Signature:____ Date: ____/____/____
(Signature of Patient or Guardian if patient is under 19)