



Patient Information

Name: _____
Last name First Middle Initial
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
May we leave you a message Y or N If NO, alternative phone: _____
Age: _____ Birth Date: _____ Gender (circle one) Female Male
Marital Status: _____ E Mail Address: _____
Please complete the following: (Note: If patient is a minor, please complete with guardian's information)
Occupation: _____ Employer: _____ Work#: _____
Parent Name (if applicable): _____
Emergency Contact: _____ Relationship: _____
Emergency Contact Phone: _____

Referring Physician or Provider

Name: _____ Phone: _____

Accident/Injury Information (if applies)

Is injury: Work related Y or N Automobile accident related Y or N
If yes to either, please provide Claim#: _____
Name of carrier: _____
Claims Manager Name: _____ Phone: _____
Date of injury: _____ Place of occurrence: _____
Are you able to continue working? Y or N

Insurance/Billing Information

Primary Insurance Co.: _____ ID# _____
Group #: _____ Are you the primary card holder for this insurance? Y or N
If no, subscribers name: _____ Subscriber's date of birth: _____
Subscriber's Employer: _____ Relationship to you is: _____
Secondary Insurance Co.: _____ ID#: _____ Group: _____
Secondary Subscriber Name: _____ Subscriber's date of birth: _____
Secondary Subscriber Employer: _____

Email: I give permission to Flex Physical Therapy to send me email messages regarding upcoming appointments. We will not sell or distribute your email address to any other entity. Initial: _____

Notice of Privacy Practice: Your personal health information (PHI) is protected and is used exclusively to administer physical therapy services and process your claims. Unauthorized disclosure of PHI is strictly prohibited. A complaint can be filed with the Privacy Officer in person or in writing at any time you feel your PHI is not being protected and the complaint will be met with full respectful attention without retaliation.

Our Notice of Privacy Practices is posted at the front desk for your review. We are happy to give you a copy if you would like a copy for your records. This describes in more detail how your health information may be used and disclosed, and how you can access your information. Initial: _____

I consent to treatment at Flex Physical Therapy. If the patient is a minor, I hereby authorize treatment as his/her parent or legal guardian.

Signature (Guardian must sign if minor) Date



FLEX PHYSICAL THERAPY FINANCIAL AGREEMENT

MEDICAL INSURANCE BILLING: As a courtesy to you, Flex Physical Therapy will bill your insurance carrier, however, you are ultimately responsible for payment of services you receive whether or not paid by your insurance. Flex Physical Therapy will verify your benefits, but this is in no way a guarantee of payment. It is your responsibility to know your policy coverage.

I authorize release of my medical records to my insurance provider at the minimum required to process my medical claim. I will keep in direct contact with my insurance provider to ensure payment in a timely manner. I understand I am responsible for ensuring any authorizations or referrals my insurance company requires are valid at the time of *each* visit.

Initial: _____

I understand that I am financially responsible for all co-pays, deductibles, and any co-insurance balances due per my contract with my insurance provider, and for any balance not paid by my insurance provider. I understand that I am obligated to remit any payments made by my insurance directly to me to Flex Physical Therapy as soon they are received. I agree to pay for all collection costs incurred by Flex Physical Therapy in the collection of any balance I owe.

Initial: _____

It is not our intention to cause undue financial hardship; however, in order to maintain our standard of care, we must collect our receivables as efficiently as possible. All patient balances, required by your insurance, are due at the time of each visit.

If at any time financial problems arise, please contact our Billing Department as soon as possible. We are happy to set up flexible payment arrangements for you.

Please note that finance charges in the amount of 12% per year, will be assessed on unpaid balances 90 days overdue.

By signing this agreement, it is understood that you, or as the guardian of a minor, understands and agrees to abide by our patient financial policy and accepts the conditions thereof.

Signed: _____
Signature of Patient or Legal Guardian

Date: _____

NO SHOWS/LATE CANCELLATIONS: Flex Physical Therapy strives to provide all our patients with the best possible care. In order to provide this care and for you to achieve your goals for recovery, it is essential that you keep all scheduled appointments.

- In order to do this, we are requesting that you provide us with a 24 hour cancellation notice. Failure to provide this notice prevents us from helping other patients during the time that you did not use. Therefore, failure to provide us with 24 hour notice will result in a charge of \$50.00 for each missed visit. This missed appointment fee is not covered by your insurance plan and will be billed to you directly and payable at the next office visit.

Initial: _____

- If you no show for a scheduled appointment, all subsequent scheduled appointments may be cancelled and will need to be rescheduled.

Initial: _____

- Additionally, if a patient is 15 minutes late to his/her appointment, we reserve the right to cancel the appointment.

Initial: _____

We do realize that on rare occasion emergencies or circumstances may arise beyond your control. We are sensitive to this fact and will address this as needed at the time of occurrence.