Name: ______________________________________
Last name First MI

Preferred Name: ______________________________

Address: ____________________________________
____

City: _______________________________________

State: ________ Zip Code: ____________________

Home Phone: _________________________________

Cell Phone: __________________________________

May we leave you a message or text reminders: Y or N

Age: _____ Birth Date: ________________________

Gender: ____________________________________

Pronouns: ___________________________________

Marital Status: _______________________________

E Mail Address: ______________________________

May we email you regarding upcoming appointments? Y or N

Occupation/Grade: ____________________________

Employer/ School: ____________________________

Work #: ____________________________________

Emergency Contact: ___________________________

Relationship: _________________________________

Emergency Contact Phone: ______________________

How did you hear about us?____

Referring Physician or Provider

Name: ______________________________________

Practice Name: _______________________________

Accident/Injury Information (if applicable)

Is injury: Work related Y or N

Automobile accident related Y or N

If yes: Claim#: _______________________________

Name of Carrier: ______________________________

Claims Manager Name: __________________________

Claims Manager Phone: _________________________

Date of injury: _______________________________

State of Injury: _______________________________

Are you able to continue working? Y or N

Insurance/Billing Information

Primary Insurance Co.: ________________________

ID#:_______________________________________

Group #: ____________________________________

Subscribers name: _____________________________

Relationship to you: ___________________________

Subscriber's date of birth: ______________________

Subscriber's Employer: _________________________

Secondary Insurance Co.: _____________________

ID#: _______________________________________

Group #: ____________________________________

Subscribers Name: _____________________________

Relationship to you: ___________________________

Subscriber's date of birth: ______________________

Subscriber Employer: ___________________________

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.

____ ____________________
Patient/Legal Guardian Signature (if under 18) Date

Printed Name: _________________________________

FLEX PHYSICAL THERAPY FINANCIAL AGREEMENT

MEDICAL INSURANCE BILLING: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, Flex Physical Therapy will bill your insurance carrier, however, you are ultimately responsible for payment of services you receive. Flex Physical Therapy will verify your benefits, however, any quotations received in no way is a guarantee of payment or coverage. It is your responsibility to know your policy coverage. Initial: ______________

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 as received.
Initial: ______________

It is not our intention to cause undue financial hardship; however, to maintain our standard of care, we must collect our receivables as efficiently as possible. Co-payments are due at each appointment. All other patient balances, required by your insurance, will be invoiced to you and are due at the time of each visit. If at any time financial problems arise, please contact our Billing Department to discuss flexible payment arrangements. Finance charges in the amount of 12% per year, will be assessed on unpaid balances 90 days overdue. If your account is sent to collections, you agree to pay for all costs incurred by Flex Physical Therapy in the collection of any balance owed. Initial: ______________

NO SHOWS/LATE CANCELLATIONS: Flex Physical Therapy strives to provide all our patients with the best possible care and will help you achieve your goals for recovery. Maximum progress and success are made when the patient is an active participant in their home exercise program and attends all appointments prescribed by their therapist.

Any appointments cancelled or broken within 24 hours of their scheduled time will be assessed a $75.00 fee. This 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 arrive later than 15 minutes after the scheduled appointment time, we may ask you to reschedule or may offer you a shorter treatment time based on what our schedule allows. If you no show for a scheduled appointment, all subsequent scheduled appointments may be cancelled and will need to be rescheduled. 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.

By signing below, you acknowledge that you have read our policies and understand your commitment to a successful physical therapy outcome is essential.

Signed: ____ Date: ________________
Patient/Legal Guardian Signature (if under 18)

Printed Name: ______________________________________

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices ("Notice") apply to Flex Physical Therapy, its affiliates and its employees. Flex Physical Therapy will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law. We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by Flex Physical Therapy. We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act ("HIPAA"). A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer at the address below.

Our full 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.

____

Signature of Patient/Legal Guardian   Date

Printed name ______________________________________