Advantage Physical Therapy

Patient's Financial Responsibility

Patient Name: _____ Responsible Party (if applicable): _____
(First, Middle, Last)

Address: _____ Name of Spouse: _____

City: _____ State: _____ Zip: _____ Home #: _____

Work #: _____ Cell #: _____ Email: _____

Date of Birth: ____ /____ /____ Sex: M □ F□ Marital Status: _____

Patient's Social Security #: _____-_____-_____ Driver's License Number/State: _____/_____

Referring Physician: _____ Date Last Seen by the Referring Physician: ___/___/_____

In Case of Emergency, please contact: _____ Phone: _____

Employer Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Insurance Policy is Through:
Employer □ Individual □ N/A □

Please Check Below:

Employee Type

Employed Full Time □ Employed Part Time □

Retired □ Not Employed □ Student □

Occupation:

Patient's Attorney Information: {if relevant, please fill out }

Attorney: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Please Read Thoroughly And Sign Below:

HIPPA Acknowledgment/ Consent

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Advantage Physical Therapy. In addition, I hereby consent to the use of disclosure of my personal health information for the purpose of treatment, payment and health care operations.

Release and Assignment

I state the above is true and if balance owing, I hereby authorize release of any information necessary to process my insurance claims and assign and request payment directly.

Patient Consent For Treatment

Having presented myself to Advantage Physical Therapy for testing and/or physical therapy services, I do voluntarily consent to the rendering of the medical testing or treatment procedures for which I am registering. I acknowledge that the services for which I am registering have been ordered by my physician. I understand that Advantage Physical Therapy personnel will carry out my physician's orders and that no guarantees or assurances have been made regarding the results or effects of these services. I accept responsibility for all charges incurred as a result of these services and agree to pay any fees not covered by insurance. Should your account be sent to a collection agency, you will by financially responsible for all collection fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

I hereby authorize Advantage Physical Therapy to release such information as required by my attorney and/or insurance company to secure my insurance benefits. In consideration of the services to be rendered, I hereby assign and transfer to Advantage Physical Therapy any benefits payable to or for my benefit under hospitalization, sickness or accident insurance, and any other insurance coverage for the payment of such services rendered. I agree to cooperate, aid and assist Advantage Physical Therapy in producing all possible insurance benefits including initiation of all policy provisions such insurance companies may require for payment.

Patient's Signature: _____ Date: _____