PhysicalTherapy
of Wimberley

Last Name First Name Date of Birth

• M • F

Social Security Number Sex Marital Status

Street Address City State Zip Code

Home Phone Number Work/Cell Phone Number

IF MINOR – Guarantor Name _____ ***Date of Birth*** _____

Address (If different from above) ***Phone Number***

Print E-mail Address _____

Best Way to Contact You • *Home Phone* • *Cell Phone* • *Email* • *Other* _____

Referring Physician: _____ Phone: _____ Diagnosis: _____

Are you receiving Home Health Care for any reason? • Yes • No If yes, where: _____

Have you ever had Physical Therapy for this Injury? • Yes • No If yes, where: _____

Emergency Contact Address Phone Number Relationship to Patient

Primary Insurance Company Primary Policy Holder • Myself • Other - Name and DOB

Member ID / Subscriber # Group

Secondary Insurance Company Primary Policy Holder: • Myself • Other – Name and DOB

Member ID / Subscriber # Group #

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PATIENT NAME_____**DATE OF BIRTH**_____

AUTO ACCIDENT OR WORK RELATED

Is your visit today the result of an accident? • Auto • Work • School Other _____
Date of Injury:_____
Employer Name_____
Employer Address _____
Employer Phone _____
State where Injury Occurred: _____
Claim Number: _____
Adjuster: _____ Phone: _____

Is the accident currently in Litigation? • Yes • No Attorney: _____
Phone:_____
Do you have a Letter of Protection (LOP)? • Yes • No
Is this covered by Personal Injury Protection (PIP)? • Yes • No

Last Name First Name Date of Birth

FINANCIAL POLICY

This is an agreement between Physical Therapy of Wimberley, as creditor and you the patient, as client/debtor. In this agreement, the terms "we", "us", and "ours" refer to Physical Therapy of Wimberley. The terms "you", "your", and "yours" refer to the client/debtor. The term "account" refers to the account that has now been established in your name to which charges are made and payments are credited. By signing this agreement, you are agreeing to pay for all services received, in the event the Insurance carrier does not cover.

PAYMENT OPTIONS

You may pay with check or credit card and payment is due at the time of service, based on the information provided above. Payment plans may be available on a case-by-case basis and must be made in advance.

INSURANCE is a contract between you and your Insurance Company. Benefits quoted to our office are not a guarantee of payment. Any discrepancies concerning specific claims are to be directed to your Insurance carrier. You are responsible for any amount not paid by your Insurance. Referrals/Prescriptions are required for Physical Therapy, and we will assist in monitoring the need for additional referrals, but **you are responsible for obtaining it**. Failure to obtain referrals/prescriptions may result in denied payment from your insurance company and become your financial responsibility.

I understand that I am ultimately responsible for the balance of my account for services rendered, if my insurance does not pay. If the law (Worker's Compensation) or my payer

contract prohibits my payment of these services, I will cooperate in the provision of information, releases, etc, to allow for timely collection from my third party payer.

Assignment of Benefits

I authorize payment to Physical Therapy of Wimberley, Inc for services rendered as a direct assignment of my benefits under my insurance policy. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

Waiver of Confidentiality

I give permission to Physical Therapy of Wimberley Clinic, Inc. to release information, verbal or written, contained in my medical record, and other related information to the following if applicable: insurance companies, rehab nurses, case managers, attorneys, employers, schools, related healthcare providers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality assurance purposes. I also understand that if my account is submitted to an attorney or collection agency or if my past due status is reported to a credit reporting agency, the fact that I receive treatment at this office may become a matter of public record.

Returned Checks There is a $25 fee for any returned checks.

Appointments

Appointments must be scheduled at our Check-In or Check-Out locations. It is the patient's responsibility to schedule; we do not offer standing appointments.

Missed Appointments For our customers' convenience, we try to maintain continuity of scheduling. **Clients with three consecutive missed appointments will be charged $25.**

Personal Injury If you are being treated as part of a personal injury lawsuit or claim, **we require payments to be made at the time of service**. We cannot bill your attorney for charges incurred due to a personal injury case. You also acknowledge that your signature also serves as an Assignment of Health Care Benefits and you authorize your attorney or liability carrier to apply those lien amounts to us out of any settlement proceeds without further authorization from you.

Personal Valuables

I hereby release Physical Therapy of Wimberley and its associates of reasonability for loss or damage to personal property, including but not limited to clothing, money, or other valuable kept in possession during my care.

_____

Patient Name – Please Print Date

_____

Signature (Parent or guardian signature if patient is a minor)

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Patient Name_____Date Of Birth_____

CONSENT FOR TREATMENT

I, *the undersigned*;

I.) authorize Physical Therapy of Wimberley to perform evaluations and treatments that my Therapist considers to be necessary for my care as outlined and prescribed by my referring physician.

II.) Recognize the practice of Physical Therapy is as much an art as a science, and therefore acknowledge that no guaranties have been or can be made regarding the level of success, or lack thereof, toward the outcome of any therapy provided.

III.) Acknowledge Physical Therapy will involve palpation (contact to the skin/tissue/joints) to my body by Therapist and/or other professional clinic staff, all of which is expressly consented for treatment.

IV.) Fully understand treatment received may or may not cause some discomfort in the form of soreness and/or pain after attending an appointment and receiving treatment.

V.) agree to contact Physical Therapy of Wimberley should any prolonged or excessive discomfort and/or pain persist in order to discuss patient options of treatment.

I am hereby consenting to the Physical Therapy treatment provided by Physical Therapy of Wimberley and its staff.

In addition, I will not hold Physical Therapy of Wimberley at fault for excessive soreness/pain not communicated immediately and will remain financially obligated for any unpaid balance(s).

_____ _____

Patient's (or parent is patient is a minor) signature Date

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Cancellation and No Show Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel an appointment with your provider please notify us at least within **24 hours of your appointment;** this will enable another person who is waiting for an appointment to be scheduled in the appointment slot. With cancellations made less that 24 hour notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 24 hour notification may be subject to **a $25.00 cancellation fee**.

Patients who do not show up for their appointment without a call to cancel an office appointment will be considered as a No Show.

The cancellations and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that Special Unavoidable circumstances may cause you to cancel within 24 hours. Fees in the instance may be waived but only with management approval.

Please sign that you have read understand and agree to this Cancellation and No Show Policy.

_____Date of Birth_____

Patient Name (please print)

_____

Signature of Patient or Patient Representative