TheraPhysical

PATIENT INFO Please Fill-Out Entire Form Completely & Legibly.

Last Name _____ First Name _____ Gender _____ Male _____ Female

Street Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell _____ Email _____

Occupation _____ Employer Name _____ Phone _____

Emergency Contact Name _____ Phone _____ Emergency Contact Relationship _____

Social Security Number _____ Date of Birth _____ Single _____ Married _____

Referring Physician _____ Phone _____

CONDITION INFO

_____ AUTO/PERSONAL INJURY Date of Accident _____

_____ WORK INJURY Date of Injury _____Company HR Person Name _____

Insurance Adjustor Name _____ Insurance Adjustor PH Number _____

_____ NO INJURY Possible Cause _____

PAYMENT INFO

_____ INSURANCE and would like to _____ Have you deal directly with them. I will assign my benefits to you by completing the "Assignment of Benefits Form" (Fees may apply in some cases). The following information is required prior to first visit: coinsurance/copay $ _____ deductible $ _____

_____ WORKERS COMP You must have all info provided under "Condition Info" section.

_____ CASH _____ CHECK _____ CREDIT

_____ I would like to apply for a Payment Plan.

_____ I have an ATTORNEY and would like to _____ Wait until my case settles before paying. I will complete the "Attorney Lien" form. Fees may apply.

REFERRAL INFO

_____ Family _____ Friend _____ Internet _____ Advertisement _____ Insurance/Directory _____ Referring Physician

_____ Other: please specify _____

Patient Signature _____ **Date** _____

IMPORTANT COMPANY POLICIES
Please read carefully and confirm your agreement by signing the bottom of this page.

10-MINUTES LATE POLICY
Being late by more than 10 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

24-HOUR ADVANCE NOTICE FEE
If you wish to change or cancel an appointment we require a minimum 24-hour advance notice. Anything less will result in a $10 fee charged to your count. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.). We don't charge you the actual cost for that appointment but rather a mere $10 fee. We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.

COPAYS ARE DUE UPON ARRIVAL
If you happen to forget your wallet or checkbook we may still be able to see you upon completion of an "Extension Request" form. This is a "promise-to-pay" form and carries a minimal fee that allows you to keep your appointment.

NO-SHOW POLICY
If you fail to show for an appointment without notice all future appointments will be removed and a $10 fee assessed to your account. You may re-schedule appointments again on a "first come, first serve basis".

CELL PHONES MUST BE SHUT OFF OR SILENT
We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set to silent mode or turn off. Thank you.

CHILDREN REQUIRING SUPERVISION ARE NOT ALLOWED TO ATTEND SESSIONS WITH YOU
Unless your facility offers child care services, you may not bring children who require supervision with you to your appointment. If your child does not require supervision and is capable of waiting for you quietly then you may bring them. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child.

FINANCIAL HARDSHIP IF APPLICABLE
If you are experiencing financial difficulties and are unable to afford the cost of our services we have a "Financial Hardship Form" which may be filled-out. If you quality for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your (patient responsibility) portions of the bill. Ask the front desk person for assistance.

IMPORTANT NOTICE FROM THE FEDERAL GOVERNMENT
It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments . . . even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP's - Take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A(a)(5) of the Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA]. Exceptional cases do apply. Please see contact info for more information. Office of Inspector General, Department of Health and Human Services. Contact by phone: 202 619-1343, by fax: 202 260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building, 333 Independence Avenue, S.W., Washington, D.C. 20201, Joel Schaer, Office of Counsel to the Inspector General, 202 619-0089.

Patient Signature _____ **Date** _____