SOUNDSIDE
PHYSICAL THERAPY, P.C.

Patient ID#_____

Patient's Name_____

Street Address (Please No P.O. Boxes)_____

City, State, Zip_____

Home Phone_____ Cell Phone_____

Email Address_____ Work Phone_____

Date of Birth_____Age_____ Sex_____ Social Security #__ __ __-__ __-__ __ __ __

Primary Care Physician (PCP) _____

PCP Address & Phone #_____

Physician who referred you to Physical Therapy_____

How did you hear of us/who recommended our office to you?_____

In case of emergency, please notify_____Phone_____

EMPLOYER INFORMATION

Employer Name_____Occupation_____

Phone Number (with extension) _____

Street Address, City, State, Zip_____

INSURANCE INFORMATION

(Please present your insurance ID card and/or cards so that we may make a photocopy)

Primary Insurance Information

Insurance Carrier_____Customer Service Phone #_____

Subscriber/Insured's Name_____Relationship (circle): Self Spouse Child Other

Insurance ID#_____Group/Policy #_____

Is there a secondary insurance? _____Yes_____No (If so, please complete information below)

Secondary Insurance Information

Insurance Carrier_____Customer Service Phone #_____

Subscriber/Insured's Name_____Relationship (circle): Self Spouse Child Other

Insurance ID#_____Group/Policy #_____

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Payment Policy

Patient Name:_____

Patient Date of Birth:_____

ALL PATIENTS ARE RESPONSIBLE FOR THEIR CO-PAYMENT
If you have a co-payment, you are responsible for that payment at the time of your office visit.

ALL PATIENTS ARE RESPONSIBLE FOR THEIR DEDUCTIBLE AND/OR CO-INSURANCE
It is our office policy to submit a claim directly to your insurance company for physical therapy services rendered to you at our facility. It is your responsibility, as the insured, to know your individual deductible, co-insurance, plan coverage and any limitations on your plan. Upon receipt of notification (payment, partial payment and/or denial) from your insurance company, we will send you a bill accordingly. Upon receipt of our invoice, you are required to make payment in full.

MEDICARE PATIENTS WITHOUT A SECONDARY INSURANCE
We are a participating Medicare provider. As a Medicare beneficiary, you are responsible for your Medicare deductible and co-insurance. Upon receipt of notification from Medicare, we will send you a bill accordingly. Upon receipt of our invoice you are required to make payment in full.

MEDICARE PATIENTS WITH A SECONDARY INSURANCE
We are a participating Medicare provider. As a Medicare beneficiary, you are responsible for your Medicare deductible and co-insurance. Upon receipt of notification from Medicare, we will gladly bill your secondary carrier. It is your responsibility, as the insured, to know your deductible, co-insurance, co-payment, plan coverage and any limitations on your plan. Upon receipt of notification (payment, partial payment and/or denial) from your secondary insurance company, we will send you a bill accordingly. Upon receipt of our invoice, you are required to make payment in full.

SIGNATURE ON FILE
I authorize payment of medical benefits directly to SoundSide Physical Therapy on my behalf for physical therapy services rendered to me.

RELEASE OF INFORMATION STATEMENT
I hereby authorize SoundSide Physical Therapy to release any information acquired in the course of treatment, requested by insurance companies and/or ancillary facilities in order to expedite my insurance claims and/or as needed in reference to my care.

PAST DUE ACCOUNTS
I understand that in the event my incurred charges become past due and are turned over to a collection agency, a 30% collection fee will be added to my bill as well as attorney fees. I hereby authorize SoundSide Physical Therapy to release any information to any collection agency deemed necessary to collect payment should my account become delinquent.

I have read and I understand this form. All information given by me is known to be true to the best of my knowledge.

Signature of Patient_____Date_____

Print Name_____

Signature of Parent /Guardian_____Date_____

Print Name of Parent/Guardian_____Relationship _____

SOUNDSIDE
PHYSICAL THERAPY, P.C.

Notice of Privacy Practices Patient Acknowledgement

Print Name:_____

Date of Birth:_____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature of Patient:_____

Date:_____

Relationship to patient (if signed by a personal representative of patient):

_____

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Informed Consent for Physical Therapy Services

Physical therapy is a patient care service that is provided in order to manage a wide variety of conditions. Services are provided to individuals of all ages regardless of gender, color, ethnicity, creed, national origin, or disability.

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. SoundSide Physical Therapy does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

Signature of Patient_____Date_____

Print Name_____

Signature of Parent/Guardian_____Date_____

Print Name of Parent/Guardian_____Relationship _____

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CANCELLATION & NO-SHOW POLICY

You will be responsible for a $20 fee for:

* Cancellations made on the same day of your appointment

* Not showing up for your appointment

I acknowledge that I have read the Cancellation & No-Show Policy

Name: _____

Signature:_____

Date:_____

As a courtesy, we can provide appointment reminders:

_____Yes, I would like to receive a reminder email. The best email to send a message is:_____

_____Yes, I would like to receive a reminder call. The best number to leave a message on is:_____

_____No, I do not wish to receive an appointment reminder.