Minor

Proactive Rehabilitation
Patient Information Form

Patient Information

Legal Name: ____________________________ ________________________________ _______ **SSN:** _____-____-______
(Last) (First) (MI)

Date of Birth: _______________ **Gender:** (circle one) **Male** **Female**

Physical Address: ____________________________________ **City:** ______________________ **State:** _____ **ZIP:** ___________

Mailing Address: _____________________________________ **City:** ______________________ **State:** _____ **ZIP:** ___________
(If different from Physical Address)

Permanent Address: __________________________________ **City:** ______________________ **State:** _____ **ZIP:** ___________
(If different from Physical Address)

☐ **Work Phone:** (____) __________________ **Text** or **Call** ☐ **Cell Phone:** (_____) ________________ **Text** or **Call**

☐ **Home Phone:** (_____) ________________ Please check the box for your preferred appointment reminder method.

Email: ____ ☐ I would like to receive paperless statements.

Are you a Student? (circle one) **Yes** **No** **Do you work?** (circle one) **Ye** _____

Mother (or Legal Guardian) __________________________________ **S** __________
Address: ______________________________________ **Phone:** (___) _ __________

Father (or Legal Guardian) __________________________________ **SS** __________
Address: ______________________________________ **Phone:** (___) _ __________

If parents are divorced/separated, who is responsible for payment? ____

Parent (Legal Guardian) Banking Information

Where do you bank? **Name:** ________________________________ **City/State:** _____________________________________

Emergency Contact

Full Name: ________________________________ **Relationship:** _______________________ **Phone:**(____) ________________

Address: ____ **City:** ______________________ **State:** _____ **ZIP:** ___________

Disclosure to Individuals Involved in Patient's Care

I authorize Proactive Physical Therapy, PC to disclose my health information that is related to my current treatment to the individual(s) listed below should they request such information. (Individuals may include spouse, parents, children, relatives, domestic partners, significant others, colleagues, etc.). **We cannot discuss your treatment or billing information with anyone without your permission.**

Name	Relationship	Information to Release
		€ Regarding Treatment €Billing
		€ Regarding Treatment €Billing

_______ (please initial)

Your Visit Today

Is condition related to: (circle one) **Employment** **Auto Accident** **Other Accident** **None**
Date of Injury: ____________________

Is an Attorney involved: (circle one) **Yes** **No** **Name of Attorney:** ___________________________________
Phone: (____) _______________

Have you had physical, occupational and/or speech therapy treatment this year: (circle one) **Yes** **No**
If yes, where? ____________________________

Proactive Rehabilitation

PLEASE TURN PAGE OVER & CONTINUE

Office Policies

	Initials
CONSENT TO TREATMENT: I hereby authorize treatment by the therapist in accordance with the Physician's orders or the therapist's initial evaluation. This authorization to treat will remain effective for 1 year from the date signed below unless revoked in writing. I understand that all information given to this office is confidential. I give permission for this office to release information in accordance with their HIPAA policy for insurance purposes, to my referring physician, or for consultation with other services. A copy of Proactive Physical Therapy, PC's HIPAA Notice of Privacy Practices was made available to me to review and/or keep so that I may know how health information about me may be used or disclosed and how I can access my own health information.	
FINANCIAL POLICY: Any benefit information we obtain from your insurance company and relay to you is not a guarantee of coverage. We assume no responsibility for any errors made by your insurance carrier or errors that are misquoted by our staff. Your insurance policy is a contract between you and your insurance carrier; therefore, it is your responsibility to understand your plan benefits. As a courtesy, we will file your insurance claims for you; however, we will not work your claims. Filing insurance claims is a service provided without charge and in no way relieves you of responsibility for your bill. It is your responsibility to ensure that your insurance company processes your claims correctly in accordance with your policy provisions. If your insurance coverage changes while undergoing treatment, it is your responsibility to notify our office of the change. You will receive an invoice from us each time we have billed charges to your insurance company as well as a monthly account statement indicating balance due. Please notify us immediately if you feel a mistake appears on your statement. You are responsible for making monthly payments on your account while you wait for your insurance claims to be processed. We will allow 45 days for insurance to process your claims. If the insurance company makes any payment directly to you for services billed by Proactive Physical Therapy, PC, you must promptly remit the payment(s) to our office. All patients with an outstanding balance for 45 days or more, will be required to establish payment arrangements with us or pay the balance in full. If written payment arrangements have not been made with us or payment in full has not been received, we have the right to limit your future credit and appointments. Do not hesitate to request special arrangements with us if you are experiencing financial circumstances beyond your control. We will make every effort possible to offer a payment plan within your budget. If the agreed-upon payment arrangements are not being followed, we have the right to turn your account balance over to our collection agency or file a Small Claims case with the Sublette County Circuit Court. If your account is placed for collection, collection agency fees of up to 40% of your account balance and/or Court and attorney's fees will be added to your balance due. Interest of 2% per month will be added to all accounts with an outstanding balance that remains unpaid for 45 days or more after notification of guarantor responsibility.	
ASSIGNMENT OF INSURANCE BENEFITS: I authorize the release of any medical information necessary to process my insurance claims. I authorize and request payment of medical benefits directly to Proactive Physical Therapy, PC. I agree that this authorization will cover all medical services until such authorization is revoked by me.	
C0-PAYMENTS: Co-payments are due at the time of service. The amount of the co-pay will be determined by our staff based on your unique billing/insurance situation. This co-pay does not cover your entire service, only a portion of it. Money collected will be applied toward the cost of your services if full payment is not received from your insurance company. Refunds will be issued, as necessary.	
WORKERS' COMPENSATION CLAIMS: If you claim Workers' Comp benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges rendered. If you have private insurance, we would be happy to bill them for denied Workers' Comp benefits. Please make sure you have provided our office with a copy of your insurance card.	
CANCELLATION & NO-SHOW POLICY: We require 24 hours notice in the event of a cancellation. The charge for cancelling or not showing for scheduled appointments is $50 per offense, beginning with the second offense. This charge is not billable to insurance and will have to be paid by you personally prior to receiving additional treatment.	
NON-SUFFICIENT FUNDS: Checks returned for Non-Sufficient Funds will be subject to a $25.00 processing fee.	
DURABLE MEDICAL EQUIPMENT (DME): Proactive Physical Therapy, PC is not a DME provider. We are unable to bill any government funded insurance companies (such as Medicare, Medicaid, and Veteran's Affairs) for any DME, such as: orthotics, splints, compression stockings, braces, etc. Patients are required to pay for DME at time of service. Other private insurance companies may also deny benefits for DME. You should contact your insurance company to verify whether DME is covered.	

I certify that I have read this form and understand its contents. I affirm that the information I provided is true, correct, and complete to the best of my knowledge and belief.

______________________________________ __________________________

Parent/Legal Guardian Signature Date

Proactive Rehabilitation

_______________________________	_______________________________
Printed Name	Relationship to Patient