WESTCOTT
PHYSICAL THERAPY

PATIENT INFORMATION

Patient Name _____ **Date of Birth** _____

Preferred Phone # _____ **Email** _____

Address _____

City _____ **State** _____ **Zip** _____

Emergency Contact _____ **Ph #** _____

Referring Physician _____

Injury/Problem _____ **Date of injury/symptoms** _____

If Medicare, has patient seen a PT this year? ☐ **Y** ☐ **N** **Where?** _____ **# of visits** _____

PRIMARY INSURED INFORMATION

Health Insurance Carrier _____

Primary Insured Name _____**Primary Date of Birth** _____

Primary Phone # _____ **Relation to patient (circle)** self spouse parent

Primary Billing Address (if different than above) _____

Patient Information Consent Form

The HIPAA Privacy Notice describes how the Practice may use and disclose my health information for the purposes of obtaining payment, carrying out treatment, evaluating the quality of services provided, and any administrative operations related thereto. I understand that the Practice is required to maintain the privacy of my health information in accordance with the terms of this Notice. By signing this form, I consent to the Practice's use and disclosure of my health information as described in the Notice. I understand I have the right to revoke this consent at any time in writing. I understand that WESTCOTT Physical Therapy will consider requests for restriction on a case by case basis, but needn't agree to these requests.

_____ _____

Signature of Patient/Legal Guardian **Date**

Payment/Policies/Medical Information Release Form

We welcome you to **WESTCOTT Physical Therapy**, and look forward to providing you with excellent treatment and service. As a courtesy, in most cases we will contact your insurance provider to verify eligibility and benefit information, which we will provide to you. **This verification is not a guarantee of benefit or payment. You should also contact your insurance company to request your physical therapy eligibility and benefits.** It is your responsibility to understand your insurance policy, which is a contract between you and your insurance provider.

Insurance and Payments: We will submit bills to most insurance companies on your behalf, and will assist you to maximize your insurance benefits. However, you are responsible for payment of all charges, including deductibles, co-insurance, co-payments and any and all denied charges. We will bill you periodically as we receive payments from your insurance company. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full by you. Insurance **co-payments** are due at the time of service. **For those without insurance**, payment in full is expected at the time of service.

Legal Costs: If it is necessary to commence legal action for the collection of any outstanding charges on your account, you will be responsible for our incurred costs and/or court fees, in addition to your outstanding balance.

Referrals: A written prescription for physical therapy may be necessary to bill your insurance. If a primary care physician's referral or a written prescription are required by the health insurance company, it is the patient's responsibility to provide us with this referral and any subsequent referrals needed for further treatment.

Cancellation/Sick Policy: We require 24 hours advance notice of cancellation; otherwise a $75.00 fee will apply. Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival of more than 15 minutes may result in shortened treatment time or cancellation. If a patient is sick, please contact us as soon as possible to cancel your appointment. A patient must be fever-free and diarrhea-free for 24 hours prior to their scheduled appointment. You will not be charged for a canceled visit due to sickness.

Financial Agreement/Assignment of Benefits: By signing below, I authorize payment of medical benefits as determined by the Insurance Company directly to **WESTCOTT Physical Therapy**. I authorize the release of any medical information relating to all claims for benefits submitted on behalf of me and/or dependents. As a patient or legal guardian, I understand I am responsible to pay for all services rendered in accordance with the terms and conditions set forth in this policy. Any money paid to me by my insurance company for services rendered and billed by **WESTCOTT Physical Therapy** shall be paid to **WESTCOTT Physical Therapy** immediately upon receipt.

My signature on this form indicates that I have read, understand, and agree to the payment/policies/medical information release of **WESTCOTT Physical Therapy**.

_____

Patient's PRINTED Name

_____ _____

Patient Signature (Legal Guardian if under 18 years old) **Date**