Print

PATIENT INFORMATION
WESTCOTT Physical Therapy

Patient Name:_____ **Date of Birth:** _____ **Marital Status:** ☐ ☐ ☐ **Single/Married/Other**

Home Phone #: _____ **Cell☐ Wk☐:** _____ **Email:** _____

Address: _____ **City/State:**_____ **Zip:**_____

Emergency Contact Name: _____ **Ph #:** _____

Referring Physician: _____ **Ph #:**_____

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

Is condition work related? ☐ **Y** ☐ **N** **Auto accident?** ☐ **Y** ☐ **N**

Has patient seen a physical therapist this year? ☐ **Y** ☐ **N** **Where?** _____ **# of visits**____

PRIMARY INSURED INFORMATION

Health Insurance Carrier: _____ **(Please provide card(s) to copy)**

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

Home Phone #: _____ **Cell☐ Wk☐:**_____ **Marital Status:** **Single/Married/Other**

Billing Address: _____ **City/State:**_____ **Zip:**_____

Patient Information Consent Form

I understand that there is a copy of WESTCOTT Physical Therapy's Notice of Privacy Practices available for me to review/take. This 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 anytime 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 **(OVER)** **Date**

SIGNATURE ALSO REQUIRED ON PAGES 2 and 3

Payment/Billing Policy/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, 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: 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. Insurance **co payments** are due at the time of service.

Payment: If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full by you. Payment for charges we have billed to you is due within 15 days of the date on your bill. Interest penalties will accrue beginning 60 days of the date on your bill at a rate of 1.5% per month. **For those without insurance**, payment in full is expected at the time of service. We accept cash, check, and most major credit cards.

Returned Checks: Checks returned to the bank for insufficient funds will be subject to a fee of **$ 25.00**.

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.

Medicare: We accept Medicare assignment. Please provide us with any secondary insurance information you may have. You will be responsible to pay any applicable co insurance, deductibles, and all Medicare allowable unpaid balances on your account. We will provide you with assistance and information regarding current Medicare policies.

Liens/MVA's: We accept liens and cases of motor vehicle accident on a case-by-case basis. Arrangements for billing will be made prior to your first visit through contact with the insurance company, adjustor or lawyer in your case. You will be responsible for any unpaid portion of your bill (please see the "Payment" section above for terms).

Referrals: In most cases, a written prescription for physical therapy will 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. If a referral is not obtained prior to your first visit and insurance denies payment, you may ultimately be held responsible for payment in full.

Cancellation Policy: 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. **We require 24 hours advance notice of cancellation; otherwise a $75.00 fee will apply.**

Financial Agreement/Assignment of Benefits:

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 policies of **WESTCOTT Physical Therapy**.

_____ _____

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