Print Form and f

PATIENT INFORMATION
WESTCOTT Physical Therapy

Patient Name: Date of Birth: Marital Status:

Phone Nbr: ◯ Cell ◯ Home ◯ Work E-Mail:

Alternate Nbr: ◯ Cell ◯ Home ◯ Work

Address

City State Zip Code

Emergency Contact Phone Nbr: ◯ Cell ◯ Home ◯ Work

Referring Physician Phone Nbr:

Injury/Problem Date of Injury/Symptoms

Is this condition a work related issue? ◯ Yes ◯ No Is this condition related to an auto accident? ◯ Yes ◯ No

Has the patient seen a physical therapist this year? ◯ Yes ◯ No Where? Nbr of visits

PRIMARY INSURED INFORMATION

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

Primary Insured Name Relationship to patient

Date of Birth Phone Nbr: ◯ Cell ◯ Home ◯ Work

☐ Check if the address is the same as above

Address

City State Zip Code

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 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: Date:

Patient Signature (Legal Guardian if under 18 years old)

SIGNATURE ALSO REQUIRED ON PAGE 2

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 deductible, 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 is 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**.

☐ I have read this form in it's entirety and agree to the policies and terms outlined above.

Signature: _____ Date: _____

Patient Signature (Legal Guardian if under 18 years old)

Payment, Cancellation and Punctuation Policies
Westcott Physical Therapy

PAYMENT POLICY

As a condition of your treatment at Westcott Physical Therapy, **payment is due at the time service is rendered**. Insured patients who have a co-pay or patients paying out-of-pocket are required to pay at each visit. We accept cash, checks, Visa, MasterCard and American Express. There will be a $25 fee for all returned checks.

CANCELLATION & PUNCTUATION POLICY

We enforce a 24-hour cancellation policy. That means **if you cancel an appointment with less than 24-hours notice, a $75 fee will be assessed for the appointment missed**. We understand that emergencies do arise in life. For all other instances, we require 24-hour notice as a simple and basic courtesy. We have an extensive waitlist that we need to accommodate when possible. This policy is in place so that we can best serve the needs of all our patients. Our priority is to spend quality time with our patients. In order to accomplish this, we schedule the appropriate time needed for each person and do not overbook, overlap, or "squeeze in" extra patients during your time. Therefore, **late arrival of a patient will result in a shortened treatment time or cancellation**. The patient will still be responsible for payment.

☐ I have read this form in it's entirety and agree to the policies and terms outlined above.

Patient's PRINTED Name: _____

Signature: _____ Date: _____

Patient Signature (Legal Guardian if under 18 years old)

Print Form E-Mail Form