



PATIENT INFORMATION

PATIENTS'S FULL NAME: _____ HOME PHONE: _____

WORK PHONE: _____ CELL PHONE: _____ E-MAIL ADDRESS: _____

MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHYSICAL ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DATE OF BIRTH: _____ SEX: M F SSN: _____ - _____ - _____ MARITAL STATUS: Single Married Widowed Other

RESPONSIBLE PARTY: _____ ADDRESS: _____

RELATIONSHIP TO PATIENT: _____ PHONE: _____ SSN: _____ - _____ - _____

EMERGENCY CONTACT: (someone that does not live with the patient) _____ PHONE: _____

PRIMARY PHYSICIAN: _____ PHONE: _____

PHYSICIAN THAT REFERRED YOU HERE: _____ PHONE: _____

DATE OF ONSET OF ILLNESS OR INJURY: (IMPORTANT FOR INSURANCE!!) _____

DUE TO: (check one) _____ WORK, _____ AUTO ACCIDENT, _____ SCHOOL, _____ OTHER _____

EMPLOYER NAME: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE NUMBER: _____ E-MAIL ADDRESS: _____

PRIMARY INSURANCE CO: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

INSURED PARTY: _____ DOB: _____ INSURANCE ID #: _____

GROUP# _____ GROUP NAME: _____ INSURED SSN: _____

SECOND INSURANCE CO: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

INSURED PARTY: _____ DOB: _____ INSURANCE ID: _____

GROUP# _____ GROUP NAME: _____ INSURED SSN: _____

IF APPLICABLE, WORKERS' COMPENSATION COMPANY: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ CLAIM NUMBER: _____ CONTACT: _____

IF APPLICABLE, ATTORNEY: _____ PHONE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I request payment of authorized insurance, prepaid medical plan, Medicare or Medicaid benefits for me, or on my behalf be made to Coulter Physical Therapy, Inc., for any services furnished me by Coulter Physical Therapy and its employees. I authorize any holder of medical information about me to release to the insurance company and the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for any charges not covered by any insurance. I consent to have therapy services as ordered by my physician.

I consent to the use or disclosure of my protected health information by Coulter Physical Therapy, Inc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Coulter Physical Therapy, Inc.. I understand that diagnosis or treatment of me by Coulter Physical Therapy, Inc. may be conditioned upon my consent as evidenced by my signature on this document. I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Coulter Physical Therapy, Inc. is not required to agree to the restrictions that I may request. However, if Coulter Physical Therapy, Inc. agrees to a restriction that I request, the restriction is binding on Coulter Physical Therapy, Inc.. My protected health information means health information, including demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review Coulter physical Therapy's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices for Coulter Physical Therapy, Inc. is provided to you on your first visit, a copy is located in the front lobby at Coulter Physical Therapy and a copy can be found on www.coulterpt.com/forms. This Notice of Privacy Practices also describes my rights and the Coulter Physical Therapy's duties with respect to my protected health information. Coulter Physical Therapy, Inc. reserves the right to change the privacy practices that are described in the notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

CANCELLATION AND NO-SHOW POLICY

We require 24 hours notice in the event of a cancellation. It is your responsibility when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number or treatments that week whenever possible. (In some cases, this may not work since some forms of treatment do not work well if given two sequential days.)

There is a \$15.00 charge for a cancellation without prior notice. This charge will not be covered by insurance, but will have to be paid by you personally before your next appointment. For Worker's Compensation and Personal Injury patients, documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.

FINANCIAL POLICY AGREEMENT

Co-pays, deductibles, and private pay agreements are due at the time of service. We will accept this on a weekly basis if you scheduled more than one time a week. **Your co-pays must be kept current each week unless other arrangements are made.** **Allowable forms of payment include cash, money order, checks, post dated checks, VISA, and Master Card.** I understand that my insurance policy is a contract between my insurance company and me, I request Coulter Physical Therapy, Inc. to file my claim form for me. I understand that I am responsible for any amount of my bill that is not covered by my insurance. I understand that if an attorney or collection agency is necessary to collect payment, I am responsible for all attorneys fees, court cost, collection agency fees and/or any other reasonable charges involved with the collection of unpaid bills.

I have read the above policies and agree to their terms. I have received a copy of the Notice of Privacy Practices for Coulter Physical Therapy, Inc.

Patient/Guardian Signature

Date