Furnace Brook Physical Therapy

_____ _____

THERAPIST DATE/TIME

WELCOME TO OUR CLINIC

PLEASE PRINT AND CONFIRM ALL INFORMATION AND COMPLETE APPLICABLE SECTIONS

PATIENT INFORMATION

Patient Name_____ Referring Physican_____

Address_____ City_____ State_____ Zip _____

Home Phone_____ Cell_____ Primary Physician _____

Date of Birth _____ SS# _____ Sex_____ Diagnosis _____

Employer _____ Address _____

City _____ State _____ Zip_____ Phone _____

Emergency Contact _____ Phone _____

Injury Result of Accident? Y or N Work Comp? _____ Auto? _____ Date of Injury _____

Have you had Physical Therapy Before? _____ Where? _____ When? _____ Insurance _____

HEALTH INSURANCE INFORMATION

PRIMARY

Insurance Co. Name_____

Address _____

City _____ State _____ Zip _____

Phone # _____ Group # _____

ID # _____

Subscriber (If other than patient) Date of Birth _____

Name _____

Relationship to patient Spouse _____ Parent ____ Other ____

Copay/Coinsurance _____

SECONDARY

Insurance Co. Name _____

Address _____

City _____State _____ Zip _____

Phone # _____ Group # _____

ID # _____

Subscriber (If other than patient) Date of Birth _____

Name _____

Relationship to patient Spouse _____ Parent ____ Other ____

Benefit _____

WORKMANS COMPENSATION INFORMATION

Insurance Co. Name _____ Claim # _____

Address _____ City _____ State _____ Zip _____

Adjustor _____ Phone _____ Ext _____

Employer at the time of Injury _____ Phone _____

Address _____ City _____ State _____ Zip _____

UR Phone _____ UR Fax _____

AUTOMOBILE INSURANCE INFORMATION

Insurance Co. Name _____ Claim # _____

Address _____ City _____ State _____ Zip _____

Adjustor _____ Phone _____ Ext _____

Name of Insured (If other than patient) _____ Relationship _____

PIP Available? _____

FURNACE BROOK PHYSICAL THERAPY PATIENT AGREEMENT

The following are our office policies. ***Please read carefully*** *before signing, and be sure to ask questions you might have prior to signing this document.*

As a condition of my treatment by Furnace Brook Physical Therapy ("FBPT") I,
_____ (Please print name) agree to the following:

1) I am responsible for understanding my own insurance coverage. I agree to contact my insurance carrier to find out if my treatment is covered and to take such steps as required to qualify my treatment for coverage. I agree to inform FBPT of any changes to my insurance.

2) If FBPT does not receive insurance authorization for my treatment, I understand that I may sign an insurance waiver, which is valid for one treatment session.

3) I agree to pay any received co-payment at every visit, or in advance.

4) I will pay for any non-covered medical supplies (ie. Theratubing, Ionto pads) at the time of the disbursement.

5) We request a 24 hour notice in the event of cancellation. I understand that treatment might be terminated if I cancel or no show for 3 appointments without rescheduling. *We only treat patients who help us get them well.*

6) If my check is returned to FBPT for insufficient funds, I agree to pay applied bank charges in addition to the amount of the check.

Consent to Treat/Informed Consent

7) I authorize FBPT to evaluate and treat my injury and perform any therapeutic procedure or treatment that is consistent with my diagnosis. I authorize FBPT (including students in training) to administer treatment under the direction and supervision of the physical therapy. I will be given the opportunity to ask questions regarding my treatment, if they so arise, and that my physical therapist will be available to answer my questions. I understand and am informed that, as in the practice of medicine, physical therapy may have some risks and my condition may worsen on rare occasions. No guarantee or promise has been made to me concerning the results of treatment. I understand that I can terminate any treatment at any time if I so desire.

Payment Guarantee

8) In consideration of the services rendered and to be rendered by FBPT, I expressly guarantee payment of my account and agree to pay any charges left unpaid in whole or in part by my insurance carrier, and that I am ultimately responsible for account totals and balance regardless of the disposition of the insurance carrier.

Assignment of Benefits

9) I authorized payment directly to Furnace Brook Physical Therapy for services rendered.

_____ _____

Signature of Patient/Parent/Legal Guardian Date