Performance Physical Therapy, Inc. (Perf PTI)

PATIENT INFORMATION:

Last Name: ______________________ **First Name:** ____________________ **MI:** ____

Address: ______________________ **City & State:** ____________ **Zip:** ________

Home Phone: ____________________ **Work:** __________________ **Cell:** ______________________

Date of Birth: ____________________ **SSN:** ______________________ **Gender:** ______________

Marital Status: ______________ **Email:** ____

EMERGENCY CONTACT:

First Name: ______________________________ **Last Name:** ________________________________

Relationship: ____________________________ **Phone:** __________________________________

EMPLOYER:

Name: ____ **Phone:** _____________________________

Address: ___________________________________ **City & State:** ______________ **Zip:** _________

PRIMARY INSURANCE:

Insurance Name: __________________________ **ID:** _________________ **Group#:** ______________

Subscriber (if not patient): ________________________ **Relationship:** ________________________

Address: ____ **Date of Birth:** _______________________

Phone #: _________________________ **Employer (if not patient):** ____________________________

SECONDARY INSURANCE:

Insurance Name: _________________________ **ID:** ____________________ **Group#:** _____________

Subscriber (if not patient): __________________________ **Relationship:** ______________________

Address: ____ **Date of Birth:** ______________________

Phone #: _________________________ **Employer (if not patient):** ____________________________

How did you hear about Performance PT? ____

OFFICE and FINANCIAL POLICIES

In order to meet the needs of as many patients as possible, Performance Physical Therapy Inc. (Perf PTI) participates with a large group of insurance plans. It is the patient's responsibility, however, to understand their plan's particular benefits.

Our Pledge

- Your plan of care will be based on the professional assessment of your Physical Therapist and Physician.
- Insurance companies will not dictate the care you receive.
- Functional goals will be established to meet your specific needs and not industry minimums set by insurance companies.
- Our fees will be fair, reasonable, and of great value for what you receive.
- If we can't help you, we will find someone who can.

1. **Financial Policy:**

- **Billing:** As a courtesy, Perf PTI will bill your insurance company. The patient is responsible for co-payments, co-insurance, and non-covered services according to their plan benefits.
- **Payments:** Depending on the type of service, payment is expected when services are rendered. Insurance companies may require co-pay or co-insurance at the time of service. Non-insurance services should be paid at the time of service. We accept Visa, Mastercard, Cash, and checks. Also, a prompt-pay discount of 20% is available if you would like to pay for you services up front. If alternative arrangements are necessary, please speak to us directly.
- **Fees:** depending upon the service, average $125.00 per visit.
- **Insurance Verification:** this is not a guarantee of payment by the insurance company. It is the patient's responsibility to know their insurance benefits and coverage.
- **The patient is responsible for all charges incurred while under care at Perf PTI.**

2. **Treating Therapist:** We believe that it is in the patient's best interest to see the same therapist at each session. Under certain circumstances, however, the patient may benefit from the expertise of a different practitioner. If this is the case, your therapist will discuss this fully with you and a mutual decision and plan will be developed.

3. **Cell Phones:** please put your cell phone on the silent or vibrate mode while in the clinic.

4. **Durable Medical Equipment (DME) and Supplies:** DME and supplies are not generally reimbursed by insurance companies, and must be paid for at the time of your session.

5. **Late charges / Returned Checks:** A $35.00 fee will be charged for all returned checks. Any account that remains open beyond 30 days from the last date of treatment will be subject to a $10.00 surcharge for each month it remains unpaid.

6. **Cancelled / Missed Appointments:** if a patient is more than 15 minutes late for an appointment, we reserve the right to reschedule. We also require a 24 hour notice for cancellations. Appointments that are cancelled with less than 24 hour notice or No-show appointments will be subject to a **$50.00** charge, not reimbursable by insurance companies.

7. **Consent for Treatment:** the patient hereby consents to the administration of evaluation and therapeutic procedures as determined appropriate by your Physical Therapist, or, as requested by the referring physician. Even though your physician may have referred you to therapy for a certain number of visits or length of time, your therapist will monitor your progress and adjust your treatment accordingly.

8. **Medical Information:** at Perf PTI we are committed to protecting your personal and medical information. During your treatment, we create records of the care you receive which we need to provide quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated at Perf PTI. We are required by law to:

   a. make sure that medical information that identifies you is kept private.
   b. give you this notice of our legal duties and privacy policies with respect to medical information about you.

ASSIGNMENT AND RELEASE

I consent to treatment and I have read and agree to comply with the above policies. I agree to accept full responsibility for all expenses incurred at Perf PTI, and I understand that the appropriate payment is due when services are rendered. I understand that this office will submit Medical charges to my insurance carrier on my behalf, however, I also understand that insurance verification is not a guarantee of payment. Therefore, I agree to pay all fees and charges that are due and not paid by my insurance carrier. It is agreed that payments will not be delayed or withheld because of insurance coverage or the pendency of claims thereon. I assign any claims payments to be made directly payable to this office. The copy of this assignment is as valid as the original. I also authorize the release of any Medical Information needed by my insurance carrier to process my claims. I also authorize payment of Medical Benefits or government benefits to this office.

I have read Performance Physical Therapy Inc.'s Financial Policy and understand that I am ultimately responsible for all charges for services provided by Performance Physical Therapy, Inc.

Name:____

Signature:____**Date:**___________

Parent's Signature:_______________________________________**Date:**___________
(if patient is under 18 years old)

If the patient is under 18 years of age and a parent is not able to attend therapy sessions with the minor, the parent(s) signature for authorization allows Perf PTI to commence physical therapy treatment with the patient who is a minor. The parent(s) is/are also accepting full financial responsibility for the treatment.