AUSTIN PHYSICAL THERAPY

Patient Information Form

PERSONAL

Name _____ Date of Birth _____

E-mail _____ Social Security#_____

Address_____

City _____ State _____ Zip_____

Home # _____ Cell # _____ Work #_____

Marital Status ❑M ❑S ❑W Sex ❑M ❑F

How did you hear about us? ❑Former Patient ❑School ❑Prof. Org ❑Golf ❑ Physician ❑Advertisement
Other:_____

How do you prefer to be reminded of your appointment? ❑Phone ❑Text ❑Email

Emergency Contact _____Relationship_____ Phone_____

EMPLOYMENT

Employer/School _____Occupation_____

Address _____City_____State_____ Zip_____

PHYSICIAN INFORMATION

***Referring Physician: _____ Phone_____

If Different, General Practioner:_____

City_____ State_____ Zip_____

Date of Injury_____ Is this an approved Workers Comp Injury? ❑yes ❑ no

Have you had Physical Therapy this year? ❑yes ❑no Is this visit a result of an Auto Accident? ❑yes ❑no

INSURANCE INFORMATION

Primary Insurance Company_____ Name of Policy Holder _____

ID#_____ Group#_____ Phone# _____

Patient Relation to Policy Holder : ❑ self ❑ spouse ❑ child

Subscribers Date of Birth _____ Subscribers Social Security # _____

Secondary Insurance Company_____ Name of Policy Holder _____

ID#_____ Group#_____ Phone# _____

Subscribers Date of Birth _____ Subscribers Social Security # _____

Patient Relation to Policy Holder ❑ self ❑ spouse ❑ child ❑ other_____

Austin Physical Therapy Financial Policy

- As a courtesy to our patients, we will verify your insurance coverage and benefits (*Verification is only a quote) as well as file therapy claims for you, however we do not accept the responsibility for settling the claim with your carrier.
- **No Show appointments: We currently have a $20 NO SHOW fee for appointments missed without prior notice. We have a limited number of appointment slots each day and we hope you recognize the value for yourself and other patients as well.**
- **We ask that you please give us 24 hours notice for any Cancellations.**
- ***If you have questions about your bill, please speak with our front office***

MEDICAL INFORMED CONSENT- I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and/or physician, I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the result of the services at Austin Physical Therapy. It is this clinic's sincere intent to educate me on every process, from billing to treatment and eventually discharge from services. Therefore, if techniques that are being used to retrain, recruit & restore postural alignment are not understood, it is my responsibility to obtain a clearer understanding of what the therapist's objectives and outcomes are, and how he/she is trying to achieve them.

I, _____ have read this form and fully understand and accept its terms and conditions.

_____

Patient/Person authorized to consent for patient/relationship Date

ASSIGNMENT AND RELEASE- I hereby authorize my insurance benefits be paid directly to Austin Physical Therapy, and understand that I am financially responsible for non-covered services. I understand that if Austin Physical Therapy does not contract with my insurance company, I will be responsible for the difference between what is charged and what my insurance pays. I also authorize the physician and /or Austin Physical Therapy to release any information necessary in order to process this claim. All of the information provided is correct and true to the best of my knowledge. **I am responsible for all charges incurred at Austin Physical Therapy.**

Signature: _____ Date _____

HIPAA- In compliance with HIPAA regulations I authorize the following individuals to receive information regarding the billing of my account.

_____ _____ _____

Name/Relationship Name/Relationship Name /Relationship

WORKMAN'S COMPENSATION

Workman's Compensation (employer's name) _____ Phone_____

Address _____ City_____ State_____ Zip _____

Claims Adjustor Name _____ Phone _____ Claim#_____

Claims Adjuster Insurance Company Name _____

Rehab Nurse Name _____Phone_____Fax_____

Nurse Case Management Co. Name _____Phone _____ Fax _____