		FERNLEY PHYSICAL THERAPY														
			PATIENT INFORMATION													
PATIENT'S FUL																
(FIRST, MI, LAS	T)															
SOCIAL SECURITY				D						DATE OF			GENDER M F			
NUMBER									BIRTH	SIRTH						
MAILING									CITY				ZIP			
ADDRESS																
HOME				CELL						MAR	ITAL	S	М	ΟΤ	HER	
PHONE									STATUS		US					
EMPLOYMENT		STUDENT EMPLOYED FT PT			РТ	RET		MPLOYED,								
STATUS											JPATI					
EMPLOYER PHONE NUMBER																
REFERRRING									PRIMAR	CARE						
PHYSICAN				DOCTOR												
IS THE INJURY ACCIDENT			Υ	N IF YES AUTO			WORK	DATE OF				OTH	IER			
RELATED?								INJURY								
EMERGENCY									PHONE:							
CONTACT						RELATIC					ATION	IONSHIP:				
ARE YOU RECEIVING HOME HEALTH SERVICES AT PRESEN						ESENT?	YES	YES NO								
HAVE YOU RECEIVED ANY PHYSICAL THERAPY Y N IF YES, WHERE?																
SERVICES THIS CALENDAR YEAR?																
WHEN?																
PRIMARY INSURANCE INFORMATION																
			-													
INSURANCE COMPANY																
POLICY HOLDER'S NAME				R						REL	RELATIONSHIP TO PATIENT:					
(Name as it appears on																
the card)									DOB:							
ID NUMBER	ID NUMBER			GROUP						CLAIM NO: WORKERS COMP						
				NUMBER												

SECONDARY INSURANCE								
INSURANCE COMPANY								
POLICY HOLDER (Name as it appears on card)			DOB					
ID NUMBER		NUMBER						
POLICY HOLDER'S SSN								
HIPAA COMPLIANCE								
I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF FERNLEY PHYSICAL THERAPY'S NOTICE OF PRIVACY PRACTICES AND I CONFIRM THAT ALL THE INFORMATION PROVIDED ON THIS FORM IS CORRECT.								
PRINT NAME:								
PATIENT/ GUARDIAN SIG	DATE							



FERNLEY PHYSICAL THERAPY ASSIGNMENT OF BENEFITS AND ACKNOWLEDGEMENT OF FINANCIAL POLICY

ASSIGNMENT OF INSURANCE BENEFITS

I HEREBY ASSIGN ALL INSURANCE BENFITS TO WHICH I AM ENTITLED TO FERNLEY PHYSICAL THERAPY, INC. I HEREBY AUTHORIZE MY INSURANCE CARRIER/S, INCLUDING MEDICARE, PRIVATE INSURANCE AND ANY OTHER HEALTH/MEDICAL PLAN TO ISSUE PAYMENT CHECKS/ELECTRONIC TRANSFERS DIRECTLY TO FERNLEY PHYSICAL THERAPY, INC. I UNDERSTAND AND ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCES. I UNDERSTAND THAT FERNLEY PHYSICAL THERAPY WILL BILL THE INSURANCES LISTED ON THE PATIENT INFORMATION SHEET. IF THE CLAIMS ARE NOT PAID DUE TO INACCURATE INFORMATION PROVIDED BY ME, I UNDERSTAND THAT I AM REPONSIBLE FOR ANY OUTSTANDING CHARGES. INITIAL

ACKNOWLEDGEMENT OF THE FINANCIAL POLICY OF FERNLEY PHYSICAL THERAPY, INC.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO ADVISE FERNLEY PHYSICAL THERAPY OF ANY CHANGES TO MY MEDICAL INSURANCE. IF I FAIL TO DO THIS, I UNDERSTAND AND ACKNOWLEDGE THAT I WILL BE FINANCIALLY RESPONSIBLE FOR ANY OUTSTADING CHARGES FOR SERVICES RECEIVED. I ALSO ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ANY CO-PAYMENTS, CHARGES THAT THE INSURANCE COMPANY ALLOCATES TOWARD MY DEDUCTIBLE AND ANY CO-INSURANCE AMOUNT. I UNDERSTAND THAT I AM RESPONSIBLE FOR KEEPING MY ACCOUNT CURRENT AND THAT IF MY ACCOUNT BECOMES PAST DUE, FERNLEY PHYSICAL THERAPY RESERVES THE RIGHT TO TURN THE ACCOUNT OVER TO A COLLECTION AGENCY. I ALSO ACKNOWLEDGE THAT FERNLEY PHYSICAL THERAPY RESERVES THE RIGHT TO PASS ANY COLLECTION FEES THEY INCURR ON TO ME FOR PAYMENT. INITIAL______

WORKMAN'S COMPENSATION PATIENTS ONLY

I UNDERSTAND THAT FERNLEY PHYSICAL THERAPY WILL OBTAIN THE REQUIRED AUTHORIZATIONS FROM THE APPLICABLE INSURANCE COMPANY.

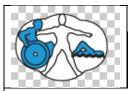
I UNDERSTAND THAT IF MY CLAIM IS DENIED AT ANY TIME DURING MY TREATMENT, I AM RESPONSIBLE FOR ANY CHARGES FOR SERVICES RECEIVED, UNTIL I PROVIDE ALTERNATIVE MEDICAL INSURANCE INFORMATION. IF I DO NOT PROVIDE THIS INFORMATION, I UNDERSTAND THAT THE TERMS OF FERNLEY PHYSICAL THERAPY'S FINANCIAL POLICY WILL BE APPLIED TO MY OUTSTANDING CHARGES.

INTIAL

I HEREBY ACKNOWLEDGE THAT I HAVE READ AND THAT I UNDERSTAND THE ABOVE POLICIES AND ASSIGNMENT OF BENEFITS.

PRINT NAME:

SIGNATURE:



FERNLEY PHYSICAL THERAPY **AUTHORIZATION FOR THE RELEASE OF PROTECTED** HEALTH INFORMATION

NAME:

I HEREBY GIVE FERNLEY PHYSICAL THERAPY, INC. PERMISSION TO DISCLOSE AND DISCUSS ANY INFORMATION RELATED TO MY TREATMENT TO THE FOLLOWING INDIVIDUALS:

NAME RELATIONSHIP

NAME______RELATIONSHIP______

APPOINTMENT REMINDERS:

TEXT MESSAGE	YES	NO	CELL NO	
E MAIL	YES	NO	EMAIL ADDRESS	

PLEASE NOTE: YOU WILL RECEIVE TEXT AND/OR E MAIL TWO REMINDERS:

- 1) 24 HOURS BEFORE YOUR APPOINTMENT.
- 2) 2 HOURS PRIOR TO YOUR APPOINTMENT.
- 3) WE DO NOT MAKE REMINDER PHONE CALLS.

I HEREBY AUTHORIZE FERNLEY PHYSICAL THERAPY, INC., TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF INSURANCE BENEFITS. I UNDERSTAND THAT THEY KEEP A RECORD OF HEALTH SERVICES PROVIDED TO ME AND THAT I MAY OBTAIN A COPY OF THESE RECORDS WITH THE UNDERSTANDING THAT A FEE MAY APPLY IF I REQUEST COPIES OF SAID RECORDS. I HEREBY AUTHORIZE THE RELEASE, TO FERNLEY PHYSICAL THERAPY, INC., OF ANY IMAGING REPORTS, DOCTOR'S NOTES OR ANY OTHER MEDICAL RECORDS THAT ARE **RELATED TO THE PHYSCIAL THERAPY TREAMENTS GIVEN TO ME.**

THIS AUTHORIZATION IS VALID FOR ONE CALENDAR YEAR FROM THE DATE OF SIGNATURE.

SIGNATURE:

D	Α	T	Έ	:



FERNLEY PHYSCIAL THERAPY

CANCELLATION POLICY

YOUR ADHERENCE TO THE RECOMMENDED FREQUENCY AND DURATION OF TREATMENTS IS A VITAL COMPONENT OF YOUR PROGRESS AND RECOVERY.

WE REQUIRE 24-HOURS NOTICE IF YOU NEED TO CANCEL AN APPOINTMENT. A REASON FOR THE CANCEL MUST BE PROVIDED.

LATE POLICY

- ✤ PLEASE CALL TO ADVISE US IF YOU ARE RUNNING LATE.
- ✤ IF YOU ARE MORE THAN 10 MINS LATE, WE WILL RESCHEDULE YOUR APPOINTMENT, IF POSSIBLE.

NO SHOW POLICY

✤ IF YOU MISS A SCHEDULED APPOINTMENT AND DO NOT CONTACT US TO CONFIRM YOUR NEXT APPOINTMENT BY NOON THE NEXT BUSINESS DAY, WE WILL CHARGE \$50 NO SHOW FEE. ANY FUTURE APPOINTMENTS WILL BE TAKEN OFF THE SCHEDULE.

CANCELLATION POLICY

♦ SAME DAY CANCELLATIONS WILL BE CHARGED A \$40 CANCELLATION FEE.

PAYMENT OF CANCEL AND NO-SHOW FEES

THESE CAN NOT BE BILLED TO YOUR INSURANCE COMPANY. ANY FEE THAT WE MAY CHARGE YOU IS YOUR RESPONSIBILITY.

I HAVE READ AND I UNDERSTAND FERNELY PHYSICAL THERAPY'S CANCELLATION AND NO-SHOW POLICY. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR THE PAYMENT OF ANY LATE, CANCELLATION OR NO SHOW FEES THAT MAY BE CHARGED TO MY ACCOUNT.

SIGNATURE_

DATE_