FERNLEY PHYSICAL THERAPY

PATIENT INFORMATION

PATIENT'S FULL NAME (FIRST, MI, LAST)									
SOCIAL SECURITY NUMBER			DATE OF BIRTH		GENDER	M	F		
MAILING ADDRESS			CITY		ZIP				
HOME PHONE		CELL		MARITAL STATUS	S	M	OTHER		
EMPLOYMENT STATUS	STUDENT	EMPLOYED	FT	PT	RET	IF EMPLOYED, OCCUPATION			
EMPLOYER						PHONE NUMBER			
REFERRRING PHYSICAN			PRIMARY CARE DOCTOR						
IS THE INJURY ACCIDENT RELATED?	Y	N	IF YES	AUTO	WORK	DATE OF INJURY		OTHER	
EMERGENCY CONTACT						PHONE:			
						RELATIONSHIP:			
ARE YOU RECEIVING HOME HEALTH SERVICES AT PRESENT?						YES	NO		
HAVE YOU RECEIVED ANY PHYSICAL THERAPY SERVICES THIS CALENDAR YEAR?	Y	N	IF YES, WHERE?						
			WHEN?						

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY				
POLICY HOLDER'S NAME (Name as it appears on the card)			RELATIONSHIP TO PATIENT:	
			DOB:	
ID NUMBER		GROUP NUMBER		CLAIM NO: WORKERS COMP

SECONDARY INSURANCE				
INSURANCE COMPANY				
POLICY HOLDER (Name as it appears on card)		**DOB**		
ID NUMBER		**GROUP 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 SIGNATURE_____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 T0 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: _____DATE_____

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:_____DATE:_____

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_____