

# **ABSOLUTE** *Physical Therapy Inc.*

How did you come to know of Absolute Physical Therapy?

Insurance List/Referral     Physician Referral     Storefront Sign     Other \_\_\_\_\_

## P A T I E N T   I N F O R M A T I O N

Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Social Security: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Sex: M F    Marital Status: M   S   W   D   Sep

Employer Name: \_\_\_\_\_ Status: FT   PT   Student    Work Phone: \_\_\_\_\_

In an emergency please contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

## P R I M A R Y   I N S U R A N C E   I N F O R M A T I O N

Insurance Company: \_\_\_\_\_ Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Copay/Coinsurance Amount: \_\_\_\_\_

Annual Deductible: \_\_\_\_\_ Deductible Paid to Date: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Sex: M   F    Relationship to patient: \_\_\_\_\_

## A D D I T I O N A L   I N S U R A N C E

Does the patient have additional insurance coverage? Y N    Insurance Company: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ Sex: M F    Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Social Security: \_\_\_\_\_ Employer: \_\_\_\_\_

## A U T H O R I Z A T I O N   T O   R E L E A S E   I N F O R M A T I O N

I hereby authorize Absolute Physical Therapy Inc. to release any information acquired in the course of my examination or treatment to my doctor and my insurance company only.

\_\_\_\_\_  
Patient or Legal Guardian's Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

## F I N A N C I A L   A G R E E M E N T

I hereby authorize payment of medical benefits directly to Absolute Physical Therapy Inc. and I understand that I am financially responsible for the charges not covered by this authorization or in the event of an industrial denial.

\_\_\_\_\_  
Patient or Legal Guardian's Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

# **ABSOLUTE** *Physical Therapy Inc.*

---

## MEDICAL ASSIGNMENT OF BENEFITS & FINANCIAL POLICY

### PLEASE READ, SIGN AND DATE

We at **Absolute Physical Therapy** are pleased to be a part of your rehabilitation experience and thank you for choosing us. We find that communication with our patients regarding our financial policy assists in providing the best service to you.

### INSURANCE BILLING

We will gladly call your insurance company to identify what your benefit plan is, however, please understand that insurance companies will not guarantee medical benefits over the phone. **Because it is ultimately your responsibility, we strongly encourage you to consult your benefits book or contact your insurance company directly, in order to understand your plan's coverage and limitations.** We can only use this information, as an estimated guideline in order to collect what your insurance company says is your "out-of-pocket responsibility." Actual determination is made 4 to 8 weeks later, after we receive the written notification and/or payments on your claim. If your insurance company makes a determination you do not agree with, it is your responsibility to contact them. Please note that we will only bill up to 2 insurance companies per claim.

Your insurance company may also require a **current prescription (prescriptions expire 30 days from the date they are written)** or pre-authorization from your physician for physical therapy services. Non-compliance with this may result in services not being reimbursed by your insurance company.

### PAYMENTS

All deductibles, copays, co-insurance and cash pay estimated amounts are due at the time of service, unless other written arrangements have been made with our facility.

Once we have received all payments or notifications from your insurance company, we will present you with your final statement. Payment for any outstanding balance will be due in full no later than 30 days from the date of your final statement. If we do not receive the payment-in-full 30 days from the date of your final statement, we may be forced to pursue legal collection proceedings and you will be responsible for the 35% collection fee incurred for collection costs.

Please do not hesitate to ask us any questions or request a copy of your account balance. Once again we appreciate your choosing **Absolute Physical Therapy**.

---

By signing this form, I the patient (or legal guardian of the patient), have read, understood and agree that I am 100 % liable for all fees incurred for services rendered here at **Absolute Physical Therapy**. I also agree to authorize **Absolute Physical Therapy** to release my medical information to insurance companies, physician(s), attorney(s) and to all other pertinent parties that may be involved in my claim or care and that I agree to assign all payment of benefits to **Absolute Physical Therapy**.

Keep in mind, your recovery period is dependent on whether you keep up with scheduled appointments. You may be subject to a \$20.00 charge if you cancel or no show with less than a 24 hour notice.

---

Patient Name (Printed)

---

Date

---

Patient (or Legal Guardian) Signature

---

Date

MEDICAL HISTORY

1. Please check if any of the following apply to you. If so, please provide further information.

- Allergies \_\_\_\_\_
- Heart Condition \_\_\_\_\_
- Seizure Disorder \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Hypoglycemia \_\_\_\_\_
- Other \_\_\_\_\_

2. Are you pregnant? \_\_\_\_\_

3. What are your physical therapy rehabilitation expectations/goals? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Please list all medications you are currently taking \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Who is your referring physician? \_\_\_\_\_

6. For industrial/workers' compensation cases only:

Case Manager: \_\_\_\_\_ Phone: \_\_\_\_\_

7. Please list prior surgeries or previous significant injuries \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**AUTHORIZATION FOR TREATMENT**

Physical Therapy/Occupational Therapy is a patient care service provided in response to a wide range of medical care needs of outpatients of all ages, regardless of gender, color, race, creed, national origin or disability, five days a week.

The purpose of Physical Therapy/ Occupational Therapy is:

- To treat disease, injury, and disability by evaluation, examination, testing, and use of rehabilitative procedures, manipulations, massage, exercise, and physical agents including, but not limited to, mechanical devices, heat, cold, air, light, water, electricity, and sound in the aid of diagnosis or treatment
- To obtain for physician information needed in diagnosis and evaluation of patients.
- To prevent or minimize residual physical and mental disability.
- To aid the patient in achieving maximum potential within his capabilities.
- To accelerate convalescence and reduce the length of the functional recovery.

All procedures will be thoroughly explained to you before they will be performed.

There are certain inherent risks with Physical Therapy/Occupational Therapy treatment because you will be asked to exert effort and perform activities with increasing degrees of difficulty, which could cause an increase in your current level of pain or discomfort or an aggravation to your existing injury. There is also a possibility that you could experience a new injury, but this risk is small and you will be able to control any procedure by stopping if you feel any increase in pain or discomfort.

You will also be able to stop treatment if you feel any discomfort in any part of your body. The Physical Therapist/Occupational Therapist and/or Physical/Occupational Therapist's Assistant will take every precaution to ensure that you are protected from any hazardous situation. You will never be forced to perform any procedure that you do not wish to perform.

Based on the above information I agree to cooperate fully and to participate in all Physical Therapy/ Occupation Therapy procedures and to comply with the plan of care as it is established.

Notice to patients: For personal safety, do not use any equipment without a staff member present.

PATIENT NAME \_\_\_\_\_

DATE: \_\_\_\_\_ PATIENT SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_ LEGAL GUARDIAN: \_\_\_\_\_

DATE: \_\_\_\_\_ WITNESS SIGNATURE: \_\_\_\_\_