Powhatan Physical Therapy

How did you hear about Powhatan Physical Therapy? (Please check all that apply)

☐ Physician Referral ☐ Friend/Family ☐ Phone Book ☐ Advertisement
☐ Former Patient ☐ Online ☐ Other: _____

Patient Information:

First Name: _____ Last Name: _____ Middle Initial: _____

Nickname: _____ Date of Birth ____/____/____ Age: ____ Sex: ☐ Male ☐ Female

Street Address: _____

City: _____ State _____ Zip _____

Home Phone: _____ Cell Phone: _____ Work: _____

E-mail: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

How would you like to receive appointment reminders? ☐ Text ☐ E-Mail ☐ Phone ☐ None

Employment Status: ☐ Full time employed ☐ Part time employed ☐ Unemployed ☐ Retired
☐ Full time student ☐ Part time student ☐ Other: _____

Occupation: _____

Emergency Contact:

Name: _____ Relationship: _____

Phone Number: _____

Referral Information:

Name of Doctor who referred you: _____

Date of your follow up visit with this Doctor: _____

(Note: This date is needed so that we can send a progress report before this appointment)

Primary Care Physician: _____

Have you attended any other outpatient physical therapy office this calendar year? ☐ Yes ☐ No

If yes, name of the physical therapy office and phone number: _____

Name: _____ Date: _____

Thank you for choosing Powhatan Physical Therapy. In order to achieve our mutual goals, we must work as a team in all elements of your care. Therefore, we may ask for your help to identify the considerations of your insurance coverage to help avoid possible future confusion. Insurance is a contract between you and the insurance company, and you are ultimately responsible for goods and services received from physical therapy. To make the financial aspects of your therapy run as smoothly as possible, we may ask that you share some information regarding your insurance coverage. Thanks for your help.

Responsible Party Information:

Name of Parent/Guardian/responsible party: _____

Address: _____

Home Phone: _____ Employer: _____ Work Phone: _____

Insurance Information:

Primary Insurance: _____

Policy Number: _____ Group Number: _____

Policy Holders Name: _____ Relationship: _____

Sex: ☐ Male ☐ Female Date of Birth _____/_____/_____

☐ **Not Applicable**

Secondary Insurance: _____

Policy Number: _____ Group Number: _____

Policy Holders Name: _____ Relationship: _____ Sex:

☐ Male ☐ Female Date of Birth _____/_____/_____

☐ **Not Applicable**

Workers Compensation:

Bill to: _____

Employer: _____

Address: _____

Phone number: _____ Claim number: _____

Patient Signature _____ Date: _____

Powhatan Physical Therapy Corporation

WRITTEN ACKNOWLEDGMENT

Our **Notice of Privacy Practices** provides information about how we may use and disclose medical information about you. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

I, (please print the patient's name) _____
have received a copy of the POWHATAN PHYSICAL THERAPY CORPORATION **Notice of Privacy Practices**.

I have had an opportunity to read the **Notice of Privacy Practices**.

I understand that I may ask questions to POWHATAN PHYSICAL THERAPY CORPORATION, if I do not understand any information contained in the **Notice of Privacy Practices.**

I understand that by my signature I authorize the release of any medical information which may serve my therapist in my treatment, i.e., any or all MRI, x-ray, or operation reports.

_____
Patient's Signature

_____
Date

-OR-

_____
Authorized Representative of Patient

_____
Relationship to Patient

_____
Date

Powhatan Physical Therapy Corporation

1799 Southcreek One, Suite E • Powhatan, Virginia 23139
Phone: 804-794-9023 • Fax: 804-794-9373

PAYMENT POLICY & AGREEMENT ASSIGNMENT OF INSURANCE BENEFITS

THANK YOU FOR CHOOSING POWHATAN PHYSICAL THERAPY CORPORATION FOR YOUR SPECIALTY CARE.

We believe that the patient-therapist relationship is based upon mutual trust and understanding, and that it is important for you to have a clear understanding of your rights and responsibilities. We ask that you carefully review the following information, and if you have any questions or concerns, please ask us.

RELEASE OF PRIVATE MEDICAL INFORMATION

By signing this agreement, you authorized POWHATAN PHYSICAL THERAPY CORPORATION to furnish any insurance carrier(s) or other third party payors or their agents, attorneys, or legal representatives all pertinent medical information which said parties may request concerning your illness or injury, which they deem necessary to determine coverage or which may be required to render payment. You also agree to assign POWHATAN PHYSICAL THERAPY CORPORATION any and all health care benefits to which you are entitled under any policy of insurance and authorized, to the extent permitted by law, payment of those benefits directly to POWHATAN PHYSICAL THERAPY CORPORATION.

PAYMENT POLICIES

By signing this agreement, you agree to pay for the following:

- Any co-payments that are required by your insurance carrier
- Any co-insurance and/or deductibles that are required by your insurance carrier
- Any charges for service that you agree to have performed, that are not covered by your insurance plan.

INSURANCE CLAIMS

POWHATAN PHYSICAL THERAPY CORPORATION will submit your claims to your insurance carrier(s) for payment. If we do not receive payment from your insurance carrier(s) within sixty (60) days of submitting your claim, we will send you a balance due statement. Upon receipt of this statement, we encourage you to contact your insurance carrier if you believe they should pay for the services, or call us to make payment arrangements for yourself.

INSURANCE REQUIRED PRIOR APPROVAL OR A REFERRAL

If your insurance carrier required prior approval or a referral, it is your responsibility to obtain the approval or referral, prior to your visit with POWHATAN PHYSICAL THERAPY CORPORATION. If you express a desire to be examined without having the required approval or referral, by signing this agreement, you agree to be responsible for payment in the event that your insurance carrier denies payment for the services you received.

PATIENTS WITHOUT INSURANCE

Patients without insurance coverage are expected to make payment arrangements with one of our Financial Counselors prior to being seen by a therapist.

PHOTOCOPYING IDENTIFICATION

By signing this agreement, you authorize POWHATAN PHYSICAL THERAPY CORPORATION to photocopy your identification cards, including, but not limited to your insurance card and driver's license.

UNPAID BALANCES

Any unpaid balances remaining on your POWHATAN PHYSICAL THERAPY CORPORATION account more than 45 days after your insurance carrier has paid, may incur a collection charge and be transferred for collection action. An additional charge of up to 28% of the unpaid balance due may be charged to cover legal costs incurred in collection. Additionally, unpaid balances may incur finance charges at the rate of 1.5% per month.

FINANCIAL DIFFICULTIES

For patients experiencing financial difficulties, we will gladly establish mutually agreed upon payment arrangements. If payments are made as agreed, no additional fees or interest will be assessed to the patient's account. If the agreed upon payment arrangements are not met, the full balance is due within 45 days. An additional charge of up to 28% of the unpaid balance due may be charged to cover legal costs incurred in collection. Additionally, unpaid balances may incur finance charges at the rate of 1.5% per month.

RETURNED CHECKS

POWHATAN PHYSICAL THERAPY CORPORATION charges a $35.00 fee for any returned check.

I have read and understand this Agreement. I agree to all the terms of this Agreement. I understand that POWHATAN PHYSICAL THERAPY CORPORATION will provide medical services to me in consideration of and reliance upon this Agreement. If the patient is a minor, an adult guarantor will be required before POWHATAN PHYSICAL THERAPY CORPORATION provides services.

_____
Print the Patient or Guarantor's Name

_____
Patient or Guarantor's Signature Date

_____
Minor Patient's Name Relationship to Guarantor

_____
Witness to Signature Date