

HARMEING PHYSICAL THERAPY AND SPORTS FITNESS INC.

_____	_____
Date	Date of birth
_____	_____
Name	Employer
_____	_____
Address	Address
_____	_____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
(_____) _____ - _____	(_____) _____ - _____
Telephone _____	Telephone _____
_____	_____
Social Security Number	Referring Physician _____ Primary Care Physician _____

Type of injury: Employer related _____ Auto accident _____ Home _____ Unknown _____ Other _____

Would you like to receive the Harmeling Physical Therapy Tip of the Month via email? Please provide your email address _____

_____	_____
Insurance Company	Secondary Insurance (if any)
_____	_____
Subscriber (name of cardholder)	Subscriber (name of cardholder)
_____	_____
Subscriber Date of Birth	Subscriber Date of Birth
_____	_____
Subscriber's Employer	Subscriber's Employer
_____	_____
Relationship to subscriber	Relationship to subscriber
_____	_____
Policy or Claim # _____ Group # _____	Policy or Claim # _____ Group # _____
_____	_____
Subscriber's Address if Different From Patient	Subscriber's Address if Different From Patient

*Who will be responsible for any expenses not covered by insurance?

In case of emergency notify: Name _____ Phone(_____) _____ - _____

Date of injury/onset: _____ Have you ever had physical therapy before? Yes _____ No _____ This calendar year? _____

****Are you currently having home health care services of any kind? Yes _____ No _____**

_____	(_____) _____ - _____
Attorney (if any)	Telephone

PLEASE READ, SIGN AND DATE THE REVERSE SIDE OF THIS FORM

**PLEASE READ THE FOLLOWING CAREFULLY
AND SIGN AND DATE BELOW**

FINANCIAL RESPONSIBILITY

I understand that I and/or my family are responsible for all services rendered by Harmeling Physical Therapy and Sports Fitness, Inc. (hereafter Harmeling PT). I further understand that I am financially responsible for, and agree to pay, all deductibles as well as any copays and/or other co-insurance not covered by my or my dependent's insurance carrier. **Copay payments will be collected upon arrival at each treatment.**

ASSIGNMENT OF BENEFITS

I hereby assign and authorize payment of all medical benefits directly to Harmeling PT, to include major medical benefits to which I, or my dependents, am entitled including Medicare and other government sponsored programs, private insurance and any other health plans for all charges incurred by me or my dependent. I hereby authorize Harmeling PT to release any and all information necessary to secure payment of said benefits.

RELEASE OF INFORMATION

I hereby authorize Harmeling PT to disclose or obtain all or any part of my, or my dependent's record, to or from any person or corporation which may be liable for all or part of the charges of Harmeling PT including but not limited to insurance companies, doctors, legal counsel, workers compensation carriers, or employers.

CANCELLATION AND NO SHOW POLICY

AFTER TWO "NO-SHOWS", THE REMAINDER OF YOUR APPOINTMENTS WILL BE CANCELLED. 24 HOUR NOTICE IS REQUIRED FOR CANCELLATION. MULTIPLE CANCELLATIONS WILL RESULT IN THE TERMINATION OF THERAPY.

Initial_____

INSURANCE REFERRALS/AUTHORIZATION

I understand that if I am a member of a private health insurance that requires referrals and or authorization for physical therapy that for each treatment for which I do not have a referral or authorization to be seen, I will be responsible for payment for services rendered should these treatments be denied by my health insurance carrier.

****IF YOU HAVE AN HMO OR MEDICARE YOUR BENEFIT IS LIMITED. ****

PLEASE ASK FOR DETAILS.

Initial_____

ELIGIBILITY AND BENEFITS

It is the responsibility of the patient or responsible party to confirm their eligibility and benefits with their health carrier. You are responsible for contacting your insurance carrier to establish what your individual benefit is for services rendered. As a courtesy, Harmeling PT checks eligibility and benefits on all patients however we can not be held responsible for misquoted benefits.

Initial_____

I HAVE READ AND UNDERSTOOD THE ABOVE

SIGNATURE: _____ DATE: _____

PATIENT (or parent if patient is a minor)