



# ADMISSION FORM

MR Number: \_\_\_\_\_

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_

Date Injured: \_\_\_\_\_

Address: \_\_\_\_\_

SS#: \_\_\_\_\_ Marital Status: S M D W O

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

Date of Birth: \_\_\_\_\_ Sex: M F

Home Ph#: \_\_\_\_\_ Work Ph#: \_\_\_\_\_

Cell Ph# \_\_\_\_\_

Employer Name: \_\_\_\_\_

Workers Comp: Y N

Employer Address: \_\_\_\_\_

Auto Accident: Y N If yes, what State? \_\_\_\_\_

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

Have you received physical therapy at other locations this year? Y N

If so, how many visits have you had? \_\_\_\_\_

## PERSON WHO SIGNS CONSENT AND IS RESPONSIBLE FOR BILL

SELF

Insured (Responsible) Party Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_

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

Home Ph#: \_\_\_\_\_ Work Ph#: \_\_\_\_\_

Employer Name: \_\_\_\_\_

## PHYSICIAN INFORMATION

Referring MD: \_\_\_\_\_ Phone #: \_\_\_\_\_ Primary Care MD: \_\_\_\_\_ Return to MD: \_\_\_\_\_

## INSURANCE INFORMATION

*If you are being seen for an injury related to work comp or an automobile accident, please give us the name of your workers compensation /automobile carrier instead of your primary personal medical insurance carrier.*

Primary Insurance: \_\_\_\_\_

Phone: \_\_\_\_\_

Group #: \_\_\_\_\_ Subscriber/SS#: \_\_\_\_\_

Pt. Relation to insured: Self Spouse Child Other

Do you have Secondary

Adjuster: \_\_\_\_\_ Claim #: \_\_\_\_\_

Insurance? Y N

Is your case in litigation? Y N

Name: \_\_\_\_\_

Attorney's Name: \_\_\_\_\_

## How did you hear about Denver Physical Therapy, P.C.? (check all that apply)

Friend/Relative? Who? \_\_\_\_\_ Physician: \_\_\_\_\_ Insurance: \_\_\_\_\_

DAC member: \_\_\_\_\_ Yellow Pages: \_\_\_\_\_ Website: \_\_\_\_\_ Other: \_\_\_\_\_

I authorize the release of any private health information necessary to process this claim.

I, the undersigned agree, whether signing as agent or as patient, that in consideration of the services rendered to the patient, to be individually obligated to pay the bill. Should the account be referred to an attorney for collection, I shall pay reasonable attorney's fees.

I hereby assign payment directly to Denver Physical Therapy, P.C., **BASIC BENEFITS** and/or **MAJOR MEDICAL** (catastrophe) **BENEFITS** herein specified and otherwise payable to me but not to exceed the regular charges for this period of treatment. I understand I am financially responsible for any charges not covered by this assignment.

I understand that upon discharge I may request, in writing, a copy of my records.

I have read, understand and signed the Denver Physical Therapy, P.C. Financial Policy on the back of this page.

Signed: \_\_\_\_\_  
Insured and/or Responsible Party

Dated: \_\_\_\_\_

## Consent for Treatment

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient at Denver Physical Therapy, P.C. I also understand that Denver Physical Therapy, P.C. may use my patient treatment data for quality assurance and research purposes, and that my name or identity will not be connected with the data.

Signed: \_\_\_\_\_  
Insured and/or Responsible Party

Dated: \_\_\_\_\_



# ADMISSION FORM OUR FINANCIAL POLICY

MR Number: \_\_\_\_\_

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our *Financial Policy* that we require you to read and sign prior to any treatment.

All patients must complete our *Information and Insurance Form* before seeing the therapist.

### REGARDING INSURANCE

We will gladly bill your insurance company directly if you have provided us with all the necessary information to do so, on a bi-weekly basis. Your contract for health insurance is between you and your insurance company. We are not a party to that contract. The physical therapy services that you receive and the bill, is an agreement between you and DPT. **It is ultimately your responsibility to see that your physical therapy bill is paid in full.** Agreements with insurance companies vary greatly and it is your responsibility to know what is their portion and what is yours. Any remaining money unpaid by your insurance company will be your responsibility to pay in a timely manner. If your insurance company does not begin paying DPT within 5 weeks, it will be your responsibility to contact them. You will be notified by mail of the balance due on your account, and you may request a statement of account if necessary. It will reflect what your insurance company, upon verification, told us is your portion to pay. We expect this payment within 15 days. If payment is not received within this 15-day period, a finance charge of 1.5% will be assessed per month. In the event a check is returned for any reason, a \$20.00 charge will be made to your account.

**REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER:** All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

If you receive payment made out to both DPT and you, please endorse the check and forward to us.

### USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances.

### ADULT AND MINOR PATIENTS

Adult patients are responsible for full payment at the time of service. The parents (or guardians) accompanying a minor are responsible for full payment of the minor's treatment. For unaccompanied minors, non-emergency treatment will be denied unless charges are paid by cash or check at the time of service.

### MISSED APPOINTMENTS

**Because we commonly have a waiting list, unless cancelled at least 8 hours in advance, our policy is to charge for missed appointments. The charge is \$25.00 for the first missed appointment and \$50.00 for second missed appointment and \$75.00 for each subsequent missed appointment. Insurance does not pay this charge. You are responsible. Please help us serve you better by keeping scheduled appointments, or call us to cancel, in a timely manner to allow another patient to have your scheduled time.**

I have read the *Financial Policy*. I understand and agree to this *Financial Policy*.

### HIPAA

I acknowledge the receipt of Denver Physical Therapy's *HIPAA NOTICE OF PRIVACY PRACTICES*.

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_

Is there anyone involved in your care, or payment of your care with whom we may share your medical information?

Yes  No If Yes, person's name: \_\_\_\_\_

Relationship: \_\_\_\_\_