PATIENT INFORMATION FORM

Last Name______________________________First Name______________________M.I.____________________
Address__________________________________City____________________State___________Zip___________
Home Phone(   )________________Work Phone(   )______________Cell Phone (   )______________________
SS#____________________Birthdate____/___ /_____Sex _____Marital Status (S M W D)
Employer____________________________________Address____

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MEDICARE INFORMATION

Policyholder's Name____Relationship to Patient____________________
Policy Number________________________________Is Medicare your only coverage? Yes [ ] No [ ]
Policyholder Birthdate ____/____/______ Retired Yes [ ] No [ ] Date of Injury_________________________

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SUPPLEMENTAL INSURANCE COVERAGE

Insurance Company Name________________________________ Address____________________________________
Phone (   )__________________ Policy Number______________________Group Name/Number_________________
Relationship to Patient (please circle) self spouse parent significant other

If other than self:

Name____________________________ Birthdate____/____/______Sex_________SS#_________________
Is this supplemental coverage paid by your past employer: Yes [ ] No [ ] If yes please complete the following:
Employer______________________________________Address____
Are you still covered by employer plan as primary coverage? Yes [ ] No [ ]

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CONSENT FOR TREATMENT

Having been made aware of my **condition** of____I, hereby grant Middletown/Holmdel Physical Therapy permission to evaluate and treat me for the above condition as prescribed by my physician. Referring Physician ___________________________Phone (   ) ____________________________

Signature__________________________________Date______________Witness_______________________________

FINANCIAL AGREEMENT

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. As a courtesy to you, we will bill your insurance carrier(s) although you are solely responsible for your balance. You are responsible for making the payments that are applied to any deductible, co-pay or coinsurance. In addition, the estimated responsibility of your bill not covered by your insurance carrier is to be paid by you at the time of service. ***Every reasonable effort will be made to collect payment from your insurance company. Denied claims will be due and payable by you within 30 days of the denial. Claims in review or appeal will be held no longer than 90 days and if payment is not received from your insurance carrier within that time, will be past due and payable by you.*** Insurance and patient refunds for any payment made in excess of the amount due will be issued when the account is paid in full. Coinsurance/copayment balances 30 days overdue will be subject to interest at the rate of 1.5% per month. ***I agree that if my account is referred to an outside agency or attorney for collection, I will be responsible for an additional Collection Fee of fifty ($50.00) or 20% of the balance owed, whichever is greater.*** If I am signing this agreement on behalf of my minor child or ward, I agree to be responsible for payment of the minor's account and to the above even in the event my minor child or ward reached the age of majority. By signing below, I understand and agree to the above.

Patient/ Legal Guardian Signature_______________________________________Date_________________________
Print Name____