

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 _____

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# _____
Employer _____ Address _____

FOR AUTOMOBILE OR WORKER'S COMPENSATION ACCIDENTS

Date of Accident ____/____/____ (Auto Work Comp) Date Reported ____/____/____
Insurance Company Name _____ Address _____
City _____ State _____ Zip _____ Phone () _____ Ext _____
Claim # _____ Claim Rep _____
Attorney Name _____ Address _____
City _____ State _____ Zip _____ Phone _____

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 _____