EAGLE ROCK PHYSICAL THERAPY

# Eagle Rock Physical Therapy Patient Information

Name_____DOB_____Gender_____

Address_____City_____State_____Zip_____

Social Security # _____

Cell_____Work_____ Email_____

Who Referred you? _____Primary Care Physician_____

**Guardian information if patient is under 18:**

Name_____Relationship to patient_____Phone_____

Address_____City_____State_____Zip_____

**Insurance Information**

Primary Insurance_____Policy #_____Group# _____

Policy Holders Name_____DOB_____Social_____

Secondary Insurance _____Policy #_____Group#_____

Policy Holders Name_____DOB_____Social_____

**History**

Exercise frequency_____Exercise Type_____

Do you smoke?_____How often?_____Are you Pregnant? _____Allergies_____

What medications are you currently taking_____

What is your main complaint for todays visit?_____Date of onset_____

Surgeries/diagnoses or medication that are being used for pain_____

_____

What prevents active daily living_____

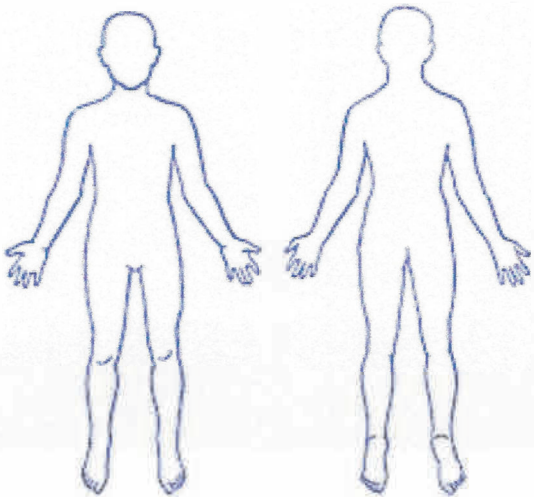
Previous doctors you have seen for this complaint_____

Aggravating Factors_____Time of day Symptoms are the best_____

Current Pain Scale 0 1 2 3 4 5 6 7 8 9 10 Is your pain?

Intermittent_____ Constant_____With Certain Motions_____

**Mark Areas of Discomfort**



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## Financial Policy & Contract for Services

In accordance with the Federal Truth-in-lending Act, all physicians are required to give their patient complete information in connection with the extension of credit. By signing this document, you agree that you have read and understand these policies.

* Basic Policy: The patient is responsible for all medical bills in this office. Our staff will help with filing of insurance claims as an accommodation and convenience to the patient without charge. It is that patient's responsibility to know their own contract benefits and to negotiate with your insurance company over disputed claims.
* Payment of any co-pays is expected at the time of service. **Co-pays and Deductibles are the responsibility of the patients and will not be written off.** It is against the law for a Provider to waive deductibles or co-pays.
* If you do not have insurance payment is due at time of service.
* If you do have insurance you are responsible for providing the insurance card and information.
* Workman's Comp In the event it is determined by a Workers Compensation Board that the illness or injury is not a result of a compensated Workers Compensation case you do herby agree by your signature to pay fees in full for services rendered.
* Forms of Payment Cash, Check, Credit Cards, Money Orders, Make checks to Eagle Rock PT
* Returned Checks there is a 15.00 charge.
* Interest Rates any bills that are not paid in 30 days, are subject to interest of 1.5% per month 18% per year regardless of insurance status, including payment plans.
* Collections if payment is not collected on a regular monthly basis the account can be turned to an outside collection agency. If this amount is assigned to an outside agency for collection you do herby agree by your signature to pay all attorneys' fees, court cost and charges or commissions that me be assessed to us by the collection agency retained to purse this matter.
* Minor Patients for all services rendered to minor patients, the adult accompanying the patient is responsible for payment at time of service.
* Office behavior anyone coming in for an appointment that is intoxicated, physically violent, or verbally abusive will not be seen.
* Cancellation of Appointment All appointments must be cancelled 24 hours prior to the appointment or you may be billed a fee of 25.00. After three missed appointments, you may discharged from the clinic.

By signing here below, I agree I have read and understand the above information. I understand that I am responsible for all of my co-pay, deductible and anything my insurance does not cover. I authorize Eagle Rock Physical Therapy and Jacob Roberts DPT, to receive assignment of all medical and/or clinical benefits to include major medical benefits to which I am entitled, including, Medicare, private insurance, and other plans. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. ERPT and Jacob Roberts DPT, is herby authorized to release my medical records to my health insurance company that may be necessary for procession of claims. If our customary charges are more than the benefits allow, I understand and agree that I will be responsible for the charges. I understand and agree to FPCS on this form and I am ultimately responsible for the balance on my account for any services rendered. I have read this completely and agree.

Signature of Patient or Accompanying Adult:

_____Date_____

### Signed Acknowledgement for Review of Notice of Privacy Practices

I have been made aware of and have had the opportunity to read and review the Notice of Privacy Practices as required by the privacy regulation created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), that is in effect for Eagle Rock PT.

_____Please Print Patients Name

_____Signature of patient or Adult with Patient

_____Date

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