Primacare
PHYSICAL THERAPY

Patient Name: _____ Birth date: _____/_____/_____

Address: _____ Cell Phone: (_____) _____-_____

_____ Work Phone: (_____) _____-_____

City: _____ State: _____Zip:_____ Sex: M or F

Emergency Contact: _____ Marital Status: M S W D

Contact Phone: (_____) _____-_____ Referring Physician: _____

Employer: _____ Physician Phone: (_____) _____-_____

Employer Address: _____ Physician Address: _____

City: _____ State: _____Zip:_____ City: _____State:_____Zip:_____

Email Address: _____

How did you hear about us? Doctor: _____ Insurance Friend/Family Internet Other: _____

Problems related to: Illness Work Related Injury Auto Accident Other

Date of Injury: _____

RESPONSIBLE PERSON INFORMATION

SAME AS ABOVE Y N

Relation to Patient: Self Spouse Parent Other

RESP. Party Name: _____ Cell Phone: (_____) _____-_____

Address: _____ Work Phone: (_____) _____-_____

City: _____ State: _____Zip:_____ Birth date: _____/_____/_____

Employer: _____ Marital Status: M S W D

Employer Address: _____ City: _____ State: _____Zip:_____

PRIMARY INSURANCE

Primary INS: _____ Phone: (_____) _____-_____

Policy #: _____ Group #_____Group Name_____

Insured Name: _____

SECONDARY INSURANCE

Secondary INS: _____ Phone: (_____) _____-_____

Policy #: _____ Group #_____Group Name_____

Insured Name: _____

I certify that the above information is valid and accurate:

Signature of Patient or Guardian: _____ Date: _____

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CONSENT FOR CARE AND TREATMENT

I, the undersigned, go hereby agree and give my consent for PRIMACARE REHABILITAION to furnish medical care and treatment to _____considered necessary and proper in diagnosing or treating his/her physical and mental condition. **Physical Therapy diagnosis is not a medical diagnosis**.

Patient/Guardian_____ Date_____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical records and/or surgical benefits to include major medical benefits to which I am entitled, including, Medicare, Medicaid, private insurance and third party payors to **PRIMACARE REHABILITATION.** A photocopy of this assignment is to be considered as valid as the original. I, hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Patient/Guardian_____ Date_____

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payments for payment of you estimated share be made today. If your insurance carrier does not remit payment with in 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal **usual and customary fee schedule,** you will be responsible for the difference remaining.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to PRIMACARE REHABILITATION.

The above does not apply for those patients that are considered Worker's Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you maybe held responsible for the total amount of charges for the services rendered to you.

When you pay by check, you expressly authorize PRIMACARE REHABILITAION, if you check is dishonored or returned for any reason, to electronically debit your account for the check amount plus a processing fee of up to the state maximum legal limit (plus and applicable sales tax). Please Note: The above language authorizes an electronic debit to your account for the state-allowed recovery fee.
I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

ESTIMATED INSURANCE BENEFITS:
Estimated Patient Payment: _____
Arrangements for payments of patient's share_____

NOTE: Estimated coverage information is provided as a courtesy to our patients but is not intended to release them form all total responsibility for their own account balance.

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

_____ _____
Patient/Guardian/Responsible Party Date

_____ _____
Center Representative/Witness Date

Primacare
PHYSICAL THERAPY

No-Show / Same-day Cancellation Policy

At Primacare Physical Therapy we expect you to get the most out of your physical therapy visits. Your physical therapist will provide you with your plan for care during the evaluation appointment and will inform you of the required number of visits to help you meet your goals. A recent study has shown that patients who adhere to their physical therapy plan of care increase their ability to have success from physical therapy by 93%.

Even one missed visit can significantly decrease your success and result in a more chronic problem. We strongly stress the importance of keeping all scheduled appointments to achieve your personal physical therapy goals.

Our schedule is very full and certain time slots are not always available for patients who need them. For this reason, we expect at least 1 days' notice if you cannot attend an appointment: for any reason. If you cannot make a scheduled appointment, for any reason, we require a day's notice of the cancellation. When you call we will assist you in rescheduling this appointment because getting you results is our main goal.

Please read the following policy and sign at the bottom indicating you understand our same-day cancellation / no-show policy and agree to adhere to the expectations listed below.

1. As experts, we know that you will not get better if you do not attend your appointment. When you call to cancel an appointment, we expect that you will have other times available so we can reschedule you right away.
2. We require that you cancel any appointment that you cannot make with no less than 24 hours' notice.
3. We will reschedule you at that time to make sure you continue with your plan of care.
4. While we understand that illness can strike at anytime, repeated cancellations for illness without 24 hours' notice will not be an accepted excuse for untimely notice.
5. For all appointments, we expect that you will arrive on time, dressed for your session, and ready to begin at your scheduled treatment time.
6. While traffic can be unpredictable, we expect that you will call us immediately if you are running late for your scheduled appointment, so we can be prepared for your late arrival.
7. Please also be aware that if you are late for your appointment, you are missing the time that we have specifically scheduled for your care and we cannot guarantee that we will be able to provide you with your full treatment as we have reserved the appointment time following yours for someone else. Chronically late patients will be asked to change their appointment times.
8. **Please note, you will be charged a $50 fee for any no-shows and ALL cancellations that occur with less than 24 hours' notice. This amount is your responsibility as insurance will not cover this fee.** To avoid the $50 fee, you simply need to call the office and provide at least 24 hours' notice for any appointments you cannot attend. Calls the night before your appointment will not count as timely notice so please call during business hours.

Thank you for reviewing this policy. Please sign and return the signed copy and keep the second copy for your records. We look forward to working with you to meet your physical therapy goals.

Dr. Ram Shahani, Owner

I have read this policy and by signing below I am indicating that I understand and will adhere to this policy.

_____	_____	_____
Patient Signature	Patient Name	Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES.

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____, had an opportunity to preview a copy of this office's Notice of Privacy Practices. (Reception folder and on the website)

_____
Please Print Name

_____
Signature

_____
Date

I authorize the following person or persons to communicate any relevant information on my behalf:

_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ❑ **Individual refused to sign.**
- ❑ **Communications barriers prohibited obtaining the acknowledgment.**
- ❑ **An emergency situation prevented us from obtaining acknowledgment.**
- ❑ **Other (Please Specify) _____**

_____ _____
Center Representative/Witness Date