# PATIENT INFORMATION

Tina L Baum Physical Therapy

| | | | | | | |
|---|---|---|---|---|---|---|
| **Patient Name (Last)** | | **(First)** | | **(MI)** | | **Home Phone** ( ) - |
| **Date of Birth** / / | **Sex** Male Female | | **SSN** - - | | | **Cellular Phone** ( ) - |
| **Age** | **Marital Status** Single Married Widowed Separated Divorced | | | | | **Email Address** |
| **Mailing Address** | | | | **City** | **State Zip** | **Code** |
| **Physical Address (If different than above)** | | | | **City** | **State Zip** | **Code** |
| **Referring Physician** | | | **How Did You Hear About Our Office?** Physician Referral Patient Internet Yellow Pages Other ______ | | | |
| **Type of Injury** ☐ Work Related ☐ Auto Related ☐ Other | | | | | | |
| **Date of Injury / Onset** / / | **Date of Surgery** / / | | **Reason for Visit** | | | |
| **Patient's Employer** | | | **Occupation Work** | | | **Phone** ( ) - |
| **Employer's Address** | | | **City** | | **State** | **Zip Code** |
| **Emergency Contact** | **Relationship** | **Address/City/State/Zip** | | | | **Phone** ( ) - |

## Spouse Information

| | | | | | |
|---|---|---|---|---|---|
| **Spouse's Name (Last)** | **(First)** | **(MI)** | | **SSN** - - | **Date of Birth** / / |
| **Address** | **City** | **State** | **Zip Code** | **Home Phone** ( ) - | |

## Insurance Information

| | | | |
|---|---|---|---|
| **Primary Insurance Company** | **Phone** | **Member/Policy ID number** | **SSN** - - |
| **Secondary Insurance Company** | **Phone** | | **SSN** - - |

## Attorney Information

| **Attorney Name** | **Attorney's Address /Zip Code /Phone Number** |
|---|---|
| | |

- **I hereby certify that all information provided is accurate and complete to the best of my knowledge.**

| ______________________ | ________ | ______________________ |
|---|---|---|
| **Patient /Responsible Party Signature** | **Date** | **Relationship to Patient** |

# FINANCIAL AGREEMENT

Tina L Baum Physical Therapy

Thank you for choosing our office as your Physical Therapy provider. Our primary mission is to provide quality of care to our patients. Your clear understanding of this form is important to our professional relationship. Please carefully review and sign this form. If you have any questions about our fees, and/or your responsibilities, please feel free to ask. These policies are subject to change with or without notice.

**Insurance:**

It is your responsibility to provide us with current insurance information. Please be aware that any amounts not covered by your insurance will be your responsibility. Our office uses a billing service to collect from your insurance; any billing statements received will come from a company called Bottomline Billing. Any failure to pay deductibles and/or co-payments may result in your account being placed with a collection agency.

**Appointment Policy:**

- **ALL FAILED APPOINTMENTS WILL BE ASSESED A CHARGE OF $50.00.**

Your appointment time will be customized to your present condition. We will not overbook appointments and waiting times should be minimal. Unfortunately, this system may compromise flexibility but will optimize your time, money and good health. Quality treatments for everyone, is based on timely arrival for appointments. There are many circumstances that may arise, on our behalf and yours, that may interrupt the flow of patient care. Please, as a courtesy to others and for your good health, arrive for appointments 10-15 minutes in advance. No call no show, cancellation without at least 24 hours notice and arriving more than 15 minutes late to be seen are all failed appointments. Failed appointment fees are the responsibility of the patient and must be paid in full prior to the next appointment. We have an answering system for which to leave messages after business hours.

**Referrals:**

If your insurance plan requires you to have a referral to be seen in our office, it is your responsibility to obtain one from your primary care physician and ensure our office has a current copy. If you are seen as a patient and later realize that a referral was needed and not obtained, you will be responsible for the total claim if denied by your insurance.

**Minors:**

The parent/guardian of the minor that has insurance coverage through will receive billing statements for the minor and will be responsible for payment on the minor's account.

**Billing Fees:**

- Billing for co-pays: Tina L Baum Physical Therapy expects the patient to pay their co-pay, estimated co-insurance or estimated deductible in full at time of service. If we have to bill you because you do not come prepared to make payment, you will be charged a $25.00 billing fee. If you forget to bring payment, you may leave and return to our office by the end of our business day to avoid this fee.
- Returned checks: There will be a $35.00 fee for any returned check as well as any fees our billing company may issue on your account

**Balances:**

Any balance on your account must be paid in full prior to your next appointment or you will have to reschedule your appointment to a later time when you are prepared to pay. Our office policy is to make sure there are no debts prior to performing additional services. If your account is currently in collections or on a payment plan, you will not be seen until the account balance is paid in full. Appointment policy will apply.

**Assignment Of Payment and Financial Responsibility:**

- I request that payment of authorized benefits be made on my behalf to Tina L Baum Physical Therapy for any services furnished to me by my provider. I authorize release of any information needed for processing of the claim to my insurance company. I understand that I am financially responsible for charges not covered by my insurance provider. I also understand that regardless of what my insurance coverage is, I will be financially responsible for all services rendered.
- Tina L. Baum will, as a courtesy to you, submit insurance claims to your insurance carrier. Prior authorizations and verification of insurance coverage will be provided by our office. Please note that verification of benefits and eligibility is not a guarantee of payment.
- Additional charges may be incurred for: interest charges for late payments and collection fees.

________________________________________ ________________________
Signature (Patient or Authorized Representative) Date

# NOTICE OF PRIVACY PRACTICES
## Tina L Baum Physical Therapy

**Acknowledgement of Notice of Privacy Practices:**

The notice of Privacy Practices tells you how we may use and share your health records. Please read it.

- We will use and share your health records to treat you and to bill for services we provide
- We will use and share your health records as required by law

All of the ways we may use and share your health records are explained in more detail in the Notice of Privacy Practices.

You have the following rights with respect to your health records

- You have the right to look at and receive a copy of your health records
- You have the right to receive a list of whom we have given your health record to
- You have the right to ask us to correct a mistake in your health record
- You have the right to ask we do not use or share your health record
- You have the right to ask us to change the way we contact you

All of these rights are explained in more detail in the Notice of Privacy Practices.

I understand that the above is a summary of Tina L Baum Physical Therapy Notice of Privacy Practices and I may request a copy.

________________________________________ ______________________________

Signature (Patient or Authorized Representative) Date

**Consent to Use and Share Health Record:**

I consent to the use and sharing of my health record for treatment, payment, and healthcare operation purposes as described to me in the Notice of Privacy Practices. I understand that if I do not consent, Tina L Baum physical Therapy cannot provide services to me.

________________________________________ ______________________________

Signature (Patient or Authorized Representative) Date