NORTH HILL PHYSICAL THERAPY, INC.

Patient Information

LAST NAME: _____ M.I._____

FIRST NAME: _____ DOB ____/____/_____

☐PATIENT UNDER 18? PARENT/GUARDIAN NAME: _____

MARITAL STATUS: ☐S ☐M ☐D ☐W SSN: _____-_____- _____

MAILING ADDRESS: _____

CITY: _____ ZIP: _____

HOME/CELL #: ( ) _____- _____
EMAIL: _____

EMPLOYER: _____ OCCUPATION:_____

WORK #: ( ) _____- _____

WORK STATUS: ☐OFF WORK ☐LIGHT DUTY ☐FULL DUTY

REFERRING PHYSICIAN: _____PHYSICIAN'S #: ( ) _____- _____

REASON FOR VISIT: _____

DID YOU HAVE SURGERY? ☐YES ☐NO *IF YES*, DATE OF SURGERY ___/____/____

ATTORNEY: _____ATTORNEY'S #: ( ) _____- _____

HOW DID YOU LEARN ABOUT OUR OFFICE?

☐DOCTOR ☐FAMILY/ FRIEND (NAME) _____

☐OUR WEBSITE ☐BILLBOARD ☐FACEBOOK ☐OTHER _____

CONFIDENTIALITY NOTICE: *I understand that all information regarding my care is privileged confidential information. I give consent to release my records for the purpose of continuation of care and/or billing purposes.*

CONSENT TO CARE: *I hereby give my consent to receive treatment as a patient at North Hill Physical Therapy, Inc.*

AUTHORIZATION OF TREATMENT OF A MINOR: *I authorize North Hill Physical Therapy, Inc. to treat the minor patient named above.*

SIGNATURE: _____ DATE: _____

(PARENT/GUARDIAN MUST SIGN FOR PATIENTS UNDER THE AGE OF 18)

NORTH HILL PHYSICAL THERAPY, INC.

Patient Insurance Information

PRIMARY INSURANCE: _____

ID#: _____ Group #: _____

Subscriber's Name: _____Date of Birth: _____/_____/_____

Patient's Relationship to Subscriber:_____

Subscriber's Social Security #:_____ -_____-_____

Subscriber's Employer:_____

SECONDARY INSURANCE: _____

ID#: _____Group # _____

Subscriber's Name:_____ Date of Birth: _____/_____/_____

Patient's Relationship to Subscriber: _____

Subscriber's Social Security #:_____ -_____-_____

Subscriber's Employer:_____

Other Insurance:_____

☐ L&I Claim ☐MVA/PIP Claim # _____

Claim Manager's name _____ Phone: ( ) _____- _____

Financial Agreement*: I understand and agree that insurance claim forms will be submitted to my insurance company as a matter of convenience only, and that I am financially responsible for any balance due. If I do not provide insurance information or inaccurate information North Hill Physical Therapy, Inc. will bill me directly for incurred charges, as well as for charges not covered by my insurance plan. If I receive a notice from my insurance company that payment is delayed or denied because of additional information is required, I will contact my insurance company so that claims may be reprocessed and paid. I also understand that I will be charged a service charge of 1% per month on any amount outstanding 60 days past due. I authorize my insurance benefits to be paid directly to North Hill Physical Therapy, Inc. In the event that my insurance company forwards payment directly to me, instead of North Hill Physical Therapy, Inc, I will immediately deliver said payment to NHPT. I understand and agree that I am wholly responsible and liable for payment of all charges assessed for professional services rendered and will pay any sum due upon demand.*

Financial Responsibility of a Minor*: It is the policy of North Hill Physical Therapy, Inc. that the parent or guardian who requests medical treatment of a minor is financially responsible for services rendered.*

SIGNATURE: _____ **DATE:** _____

(PARENT/GUARDIAN MUST SIGN FOR PATIENTS UNDER THE AGE OF 18)

NORTH HILL PHYSICAL THERAPY, INC.

Policies

Insurance Billing Policy

We are Preferred with most insurance companies. However, we strongly suggest all patients call their insurance company to verify their Outpatient Physical Therapy Benefits. NHPT will bill with the information provided to us at your initial visit. If other insurance is provided at a later date, NHPT may choose to re-bill with an administration fee added.

Safety Policy

For the safety of all patients and children we request that all children under the age of 6 years old be supervised by a non-patient adult in the waiting area.

Attendance Policy

We do understand that emergencies and unforeseen circumstances can arise. However, if you know in advance that you will be late or unable to attend that day's appointment we would **appreciate a phone call**.

Privacy Policy

Your privacy is very important to us. We will only authorize to release information to you, your Doctor and your Insurance Company. Our privacy policy can be obtained upon request and on our website.

Workers Compensation Policy

Your therapist, physician, adjuster and case manager all work together to assist with your return to work. For your treatment to have maximal effect and progress, all sessions must be attended. To comply with the L&I laws, we are required to notify the adjuster, case manager and physician of missed appointments. If for any reason, you are unable to attend, please call and we will reschedule and inform your adjuster. Missed appointments may result in discontinuation of your workman's compensation benefits and claim closure.

I have read and understand/agree to the above statement.

SIGNATURE: _____ DATE: _____

(PARENT/GUARDIAN MUST SIGN FOR PATIENTS UNDER THE AGE OF 18)

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NORTH HILL PHYSICAL THERAPY, INC.

Information Disclosure

North Hill Physical Therapy, Inc.

HIPPA laws limit our ability to discuss your private information with your family members, or other persons close to you.

If you would like to grant us permission to speak with a person other than yourself regarding your protected health information (including any billing information), please list their names and information below.

Name: _____ Name: _____

DOB: _____ DOB: _____

Relationship to you:_____ Relationship to you:_____

Name: _____ Name: _____

DOB: _____ DOB: _____

Relationship to you:_____ Relationship to you:_____

Would you like to grant us permission to leave a detailed message on your voicemail?
(Examples may include appt. verification, problems regarding your insurance coverage, account issues, etc.)

☐Yes, permission granted. Please leave detailed messages for me.

☐No, permission denied. Please leave name & number messages and I (the patient or guardian) will return your call.

SIGNATURE: _____ DATE: _____
(PARENT/GUARDIAN MUST SIGN FOR PATIENTS UNDER THE AGE OF 18)