

Valley Rehabilitation, Ltd.
PHYSICAL THERAPY

Patient Information Sheet

PLEASE PRINT CLEARLY

Patient Information

NAME: _____
First Middle Last

LOCAL ADDRESS: _____
Street City Zip Apt. #

OUT OF STATE ADDRESS: _____
Street City State Zip Apt. #

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

SOCIAL SECURITY # _____ AGE: _____ DATE OF BIRTH: _____

SEX: M / F MARITAL STATUS Single Married Widowed Divorced

REFERRING PHYSICIAN: _____ DATE OF ONSET OR INJURY: _____

EMERGENCY CONTACT NAME _____ AND PHONE # _____

Name of relative not living with you _____ Phone # _____

Responsible Party/ Insurance Information

INSURANCE INFORMATION:

Primary Insurance Name: _____

Street Address City State Zip Insurance Phone
Policy #: _____ Group # _____ or Claim #: _____
Cardholder's Name: _____ DOB: _____ SS#: _____
Relation to Patient _____ OCCUPATION _____

Secondary Insurance Name: _____

Street Address City State Zip Insurance Phone
Policy #: _____ Group # _____ or Claim #: _____
Cardholder's Name: _____ DOB: _____ SS#: _____
Relation to Patient _____ OCCUPATION _____

Is Medicare your Primary Insurance? Yes _____ No _____ Are we to bill Medicare: Yes _____ No _____

Have you had any Outpatient Physical Therapy or Speech Therapy treatments at any other facility during this year? Yes ___ No ___

Have you had any home health care this year? Yes ___ NO ___ If yes, please inform our Billing Manager

INDUSTRIAL INJURY- WORKMAN'S COMP

Employer Name Street Suite # City State Zip Phone #

If this is a job related injury, is this the employer you were working for at the time? Yes ___ No ___

If due to an injury, date of loss: ___/___/____. First symptoms: _____

Claim # _____ Case Manager _____ Phone _____

INJURY DUE TO ACCIDENT? Yes _____ No _____

Will an attorney or Liability carrier be involved in payment of charges? (circle) YES NO

If yes, please explain _____.

We thank you for choosing our facility for your physical therapy treatments and we sincerely hope that your experience with us is a positive one. Our staff is very diligent in obtaining insurance authorization and approval for all of our patients to help alleviate any unforeseen insurance denials. However, as you may be aware, it is becoming increasingly more difficult to find insurance plans willing to commit to payment until after a charge is billed. Therefore if you agree to the terms listed below, we assure you that we will work with you and your insurance plan to help insure that your out-of-pocket expense is minimal for you.

ASSIGNMENT & RELEASE OF INFORMATION / FINANCIAL RESPONSIBILITY:

I hereby assign my insurance benefits, to Valley Rehabilitation, Ltd. for services rendered and authorize and direct my insurance carrier to pay my benefits directly to Valley Rehabilitation, Ltd. I am financially responsible for charges which are not paid by the insurance carrier. I also authorize Valley Rehabilitation, Ltd. to release information required, or to request medical information about me for: filing insurance claims, my physician, or for any ancillary facilities that are involved with my care.

I am fully responsible for all co-insurance, deductibles, co-pays, etc. Should my therapist initiate a treatment that utilizes supplies that my insurance company refuses to pay for, I am responsible for payment of those supplies. I understand that Valley Rehabilitation, Ltd. will do everything possible to help insure payment by obtaining authorization when necessary from my insurance company, but will not be held responsible should my insurance deny payment for any reason. I am also responsible for reading and understanding the terms and conditions of my own contract with my Insurance Company and will not hold Valley Rehabilitation, Ltd. accountable for claims denied by my Insurance Company for any reason. After 60 days, of non-payment, Valley Rehabilitation, Ltd. will bill me for the charges which are due at the time of receipt of invoice. Should I not pay my charges in the time designated by Valley Rehabilitation, Ltd. I agree to pay all legal and court costs, as well as any collection fees (25% of my balance) that may be incurred by Valley Rehabilitation, Ltd. in trying to collect the funds owed. In addition, there may be further collection fees required by the collection agency. In the event that my insurance company requests a refund of payments made, I will be responsible for the amount of money refunded to my insurance company. If any payment is made directly to me by my insurance company, I agree to remit that payment to Valley Rehabilitation, Ltd.

The above does not apply if I have asked Valley Rehabilitation, Ltd. to file an industrial claim for me. However, if the charges are denied by the insurance company, I will be responsible for full payment to Valley Rehabilitation, Ltd.

I also understand that Valley Rehabilitation, Ltd. will not bill my insurance company if I do not show up for my scheduled appointment. However, Valley Rehabilitation, Ltd. will bill me \$50.00 for a no-show visit, of which I am responsible, if I do not give Valley Rehabilitation, Ltd. at least 24 hours notice.

Should I owe Valley Rehabilitation, Ltd., any sum of money, I agree to make payment in full by the time requested, unless payment arrangements have been made.

I have read and agree to the above, and I certify that all information that I have given is true and correct.

I understand that Valley Rehabilitation, Ltd. will bill my insurance carrier as a courtesy and convenience to me. However, I am ultimately responsible for the entire charges should my insurance refuse to pay my claims.

Signature of Patient / Guardian / Responsible Party

Date

Witness

Date

It is the desire of Valley Rehabilitation, Ltd. to provide you with the best possible care. We appreciate your business and your cooperation.