

WELCOME TO FOUR SEASONS PHYSICAL THERAPY

Today's Date: _____ Have you had other Physical, Massage, Speech or Occupational Therapy during the current calendar year? (circle one) yes - no If YES, where? _____

Patient Name: _____ Male / Female (First) (M.I.) (Last)

Address: _____ City: _____ Zip Code: _____ (Spokane, Nine Mile Falls, Other: _____)

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Can we call you at work? Yes / No

Marital Status: (circle one) Single - Married - Divorced - Widowed

Date of Birth: ____ / ____ / ____ Social Security # _____ (mm dd yyyy)

Employment Status: (circle one) Full Time - Part Time - Unemployed - Retired

Patient's Employer: _____ (Business Name) (Business Address & Phone Number)

Spouse's Name: _____ Spouse's Employer: _____ Spouse's DOB: ____ / ____ / ____ (mm dd yyyy)

Spouse's Contact # _____

Guarantor (Complete if Patient is a Minor/Child): _____ Relationship to Patient: _____

Home Phone: _____ Work Phone: _____ Address: _____

Primary Physician: _____ Date last seen: ____ / ____ / ____ (mm dd yyyy)

Referring Physician: _____ Date last seen: ____ / ____ / ____ (mm dd yyyy)

Emergency Contact: _____ Phone: _____ (Name & Relationship to Patient)

Who can we thank for your referral? _____

Do you currently have an open pip claim under your auto insurance? Yes No

Have you sustained an on-the-job injury? Yes No

Complete only if AUTO or ON-THE-JOB injury claim:

Name of Insurance Co: _____ Phone: _____

On-The-Job/Employer & Address at time of injury _____

Have you had physical therapy for this accident? Yes No If yes Where _____ When ____ / ____ / ____ (mm dd yyyy)

Claim # _____ Date of Injury: ____ / ____ / ____ Contact Person: _____

State of accident: _____ (mm dd yyyy)

Primary Medical Insurance: _____ Policy Holder: _____

Have you received Home Health Services this calendar year? _____ If yes name of agency _____

Secondary Insurance: _____ Policy Holder _____

PLEASE PRESENT INSURANCE CARD, COPAYMENT, AND IDENTIFICATION AT THE TIME OF TREATMENT

****CONTINUED ON BACK****

FOUR SEASONS PHYSICAL THERAPY, LLP

**Thank you for choosing Four Seasons Physical Therapy for your treatment.
Please review the following policies and consult the front desk if you have any questions.**

FINANCIAL POLICIES

Payment is required at time of service unless other arrangements have been made. Copays are due at the time of service. We accept Visa, Mastercard, cash or check.

We will bill your insurance company if you provide complete and accurate billing information. Our office will make every effort to help you track your insurance benefit limits, however, *it is ultimately the patient's responsibility to know their own benefit limits and/or maximums allowed on their insurance coverage.*

Balances remaining after payment from your insurance company are your responsibility and are due and payable within 30 days.

Injury and accident claims are contingent upon your claim being accepted for payment by the carrier.

Regardless of any unfortunate or extenuating circumstances that have initiated your need for our service, you are ultimately responsible for payment of your account. There are no exceptions. If you have retained an attorney, we can extend a monthly payment plan to you for up to one year. Your minimum monthly payment is based on the potential balance of your account relative to your treatment in our office. After one year, we will re-evaluate your account. If at any time we do not receive requested information regarding your legal process, or you fail to make regular monthly payments, we have the option to require the unpaid balance be paid in full immediately. *We do not accept third party claims.*

APPOINTMENT/CANCELLATION POLICY

Appointment changes/cancellations must be made no later than 8:00 a.m. on the day of your appointment.

Failure to give adequate notice for cancellation will result in a \$25.00 charge. This fee will be due before any additional appointments can be scheduled. *Regular attendance is necessary for optimum benefit of treatment.*

RETURN CHECK POLICY

A non-negotiable **\$20.00** charge will be assessed per returned check. Our bank charges us a fee for returned checks and we are passing this fee onto you.

PRIVACY POLICY

This office complies with national privacy standards to protect personal health information as required by HIPAA.

ACKNOWLEDGMENT

By signing below,

- I certify that I have read and understand the above office policies
- I certify the information I have provided is true and correct
- I give consent for physical therapy treatment
- I authorize my records to be released to other healthcare providers and/or any entity responsible for payment of my account
- I authorize payment from Medicare and/or my insurance carrier be made directly to Four Seasons PT
- I accept financial responsibility for services provided that are not covered by my insurance company
- I am aware of the Privacy Policy & a copy in its entirety is available at my request from the front desk

Signature: _____ **Date:** _____