HARTZ Physical Therapy

Demographic Intake

Date: _____

Patient's Legal Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Birthdate: _____ Sex: F/M SS#: _____ Marital Status: S/M/W/D

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Referring Physician: _____

Family Physician: _____

Employer: _____

Worker's Compensation or Auto Insurance Claims:

Insurance Company Name: _____

Address: _____

Phone#: _____ Adjustor's Name: _____

Claim #: _____ Date of Injury: _____

Do you have personal insurance? YES / NO

Primary Insurance_____ ID#_____

Group#_____ Policyholder's name:_____

If ever a claim is denied or benefits are exhausted you will be responsible for any unpaid charges.

Previous Physical Rehabilitation:

In the last year, have you had Physical Therapy anywhere else? YES / NO

If so, please provide number of visits and Discharge Date:

Home Health (PT visits your home) _____

Chiropractic Services _____

PT in a Physician's office _____

Other: _____

CANCELLATION POLICY

We know you have a choice in your care and we are pleased that you chose HARTZ Physical Therapy for your rehabilitation needs. We have made it our priority to provide the highest level of care to our patients. We schedule in such a way that allows plenty of time to ensure you are able to receive your treatment and ask questions without feeling rushed. **We block this time just for you!**

As we go through this process together, we ask that you be aware of the importance of attending your scheduled sessions and our policies for canceling appointments.

- **Please be on time:** Your therapist has many patients scheduled throughout the day and a late arrival may prohibit our ability to treat you. Late arrivals may affect your progress and inconvenience the patients who are on the schedule after you.
- **12:00 PM Business Day Before Notice:** If you find you do need to cancel, please inform our office by 12:00 PM the business day before your appointment. We will do our best to reschedule your appointment. Please note: If your appointment is on a Monday, please call by 12:00 PM on the Friday before.
- **Cancellation Fee:** You will be charged a $50 cancellation fee for any appointments cancelled after 12:00 PM the business day before your scheduled appointment time unless that appointment can be rescheduled in the same week.
- **NO SHOWS** are subject to the same $50 cancellation fee.

We respect your time by minimizing wait times in the reception area upon arrival and blocking our therapist's schedule just for you. We ask that you respect our time as well by arriving on time for your scheduled appointments and providing appropriate notice should you need to cancel an appointment.

We thank you for your cooperation and look forward to helping you achieve your functional goals!

My signature on this form indicates that I understand I will be charged a $50.00 cancellation fee if I do not provide notice of cancellation prior to 12:00 PM the business day before my scheduled appointment.

_____ _____

Signature of Patient or Responsible Party, if minor Date

HARTZ Physical Therapy

Permission for Release of Information

Patient's Full Name: _____
(Last) (First) (Middle)

Patient's Date of Birth: _____/_____/_____ Telephone:_____

Name:_____Relationship to Patient: _____

Name:_____Relationship to Patient: _____

Name:_____Relationship to Patient: _____

HARTZ Physical Therapy uses a reminder system to communicate with our patients. Please complete the information below, so that we may keep in touch with you regarding your health.

Cell Phone: _____ (you will receive a text message)

E-mail: _____ (you will receive an email)

*You may choose to do both methods of communication. By providing your email address we are able to send direct links to your home exercise programs. All email addresses are private. We will never sell or spam your account.

By signing, I give permission to HARTZ Physical Therapy to share my protected health information to the individuals listed. This Permission remains in effect until revoked in writing.

_____ _____

Signature of Patient or Authorized Representative Date

HARTZ Physical Therapy

General Policies and Consent Form

Consent to Treat

I consent and authorize for myself or a minor child under my legal care to be evaluated by the medical personnel of HARTZ Physical Therapy. I understand that no guarantee has been made to me about the outcome of my care. I understand that HARTZ Physical Therapy works with academic institutions to provide healthcare students training and learning opportunities and that they may be involved in my care, under the supervision of appropriate personnel. I understand I have the right to refuse the involvement of healthcare students in my care.

HIPAA

I understand HARTZ Physical Therapy is in full compliance with the Health Insurance Portability and Accountability Act. By signing below, I acknowledge I have access to HARTZ Physical Therapy's Notice of the Privacy Act.

Consent to Bill Insurance

I consent and authorize HARTZ Physical Therapy to bill my insurance on my behalf and authorize my insurance company and/or attorney make payments directly to HARTZ Physical Therapy for services rendered. I understand that it is my responsibility to ensure that HARTZ Physical Therapy has all the necessary information to bill my insurance and that I could be responsible for payment if my claims are denied due to inaccurate insurance information provided by me. **I understand that the insurance benefits quoted to HARTZ Physical Therapy by my insurance company are not a guarantee of payment.**

Co-pays

Your insurance company determines your co-pay. By law, we are required to collect this at the time of visit. Please be prepared to pay your co-payment at each visit. We accept cash, check and credit cards (MasterCard, Visa and Discover). Returned checks shall result in a $25 fee.

Worker's Comp/Auto Insurance

For those patients who are covered under a Worker's Comp or Auto Insurance plan, we will need the insurance company name, phone number, contact name, claim number and date of injury. We will also ask for your personal health insurance information which will be billed, should Worker's Comp be denied, or Auto Insurance becomes exhausted. In that case, you will be responsible for any unpaid charges.

Excluded or Non-Covered Services

Each insurance plan determines which medical services will be covered. Patients are responsible for services not covered under your insurance plan.

Delinquent Accounts

If your account becomes delinquent and is sent to a collection service, you will be assessed a 33% collection fee. If an extended payment plan has been offered to you, we require you to make at least a monthly payment on your balance due.

Signature

Your signature on this form acknowledges that you have received and agree to HARTZ Physical Therapy's General Policies for yourself or a minor child. You understand and fully agree that you have full responsibility to pay HARTZ Physical Therapy for all services rendered.

Signature: _____ Date: _____