HARTZ Physical Therapy

Patient's Legal Name: _____ Date: _____

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

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

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

Guarantor: (if other than patient) _____ Guarantor DOB_____

Referring Physician: _____ Family Physician: _____

Employer: _____Email Address: _____

Contact Preference: (please circle): Email Phone Call Text

Health Insurance Information

Primary Insurance: _____ Phone number:_____

Billing Address: _____

ID#: _____ Group #: _____

Policyholder's Name: _____ Relationship:_____

Secondary Insurance: _____ Phone number: _____

Billing Address: _____

ID#: _____ Group #: _____

Policyholder's Name: _____ Relationship: _____

Worker's Compensation or Auto Insurance Claims:

Insurance Company Name: _____

Address: _____

Phone#: _____ Adjustor's Name: _____

Claim #: _____ Date of Injury: _____

Previous Physical Rehabilitation:

In the last year, have you had Physical Therapy elsewhere? (circle one) 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 _____

HARTZ Physical Therapy

Treatment Consent: I hereby give consent for the authorized personnel of HARTZ Physical Therapy to perform an evaluation, render treatment and provide physical therapy education to me or to a minor child under my legal 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.

Release of Information: I give permission to HARTZ Physical Therapy to release medical information or other information necessary for treatment, billing and payment. HARTZ Physical Therapy will release information as permitted by law. In addition, information pertaining to the physical therapy treatment may be obtained from other medical providers.

I hereby authorize verbal or written release of information to the following person:

_____ _____

Name Relationship

Cancellation Policy: HARTZ Physical Therapy has a 24-hour cancellation policy. A $20 charge will be collected from you for failure to give a 24-hour cancellation notice or no show for an appointment. This fee is not billable to your insurance company. It is due at your next visit.

Financial Policy: As a courtesy to our patients, we submit insurance claims directly to your insurance company. It is your responsibility to make sure we have all the necessary insurance information, including complete address and identification numbers**. The insurance benefits quoted to us by your 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 only).**

Worker's Comp/Auto Insurance: For those patients who are Worker's Comp or Auto Insurance, we will require the insurance company name, phone number, contact name, claim number and date of injury. We will also ask you for your personal health insurance information should Worker's Comp be denied, or Auto Insurance become 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 those services not covered under your insurance plan.

Returned Check Fee: A returned check shall result in a $25 fee.

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.

I understand and fully agree that I have full responsibility to pay HARTZ Physical Therapy for all services rendered.

_____ _____

Signature of Patient, Power of Attorney, or Guardian, if a minor Date