ALBATROSS™
PHYSICAL THERAPY AND WELLNESS

Patient Information Form

Name: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Email address: _____

Home Address: _____

City: _____ Zip Code: _____

Spouse's Name: _____ Work Phone: _____

Social Security #: _____

Date of Birth: _____

Nearest Relative not living with you: _____ Phone: _____

Nearest friend not living with you: _____ Phone: _____

Primary Care or Referring Physician: _____ Phone: _____

Doctor: _____ Phone: _____

Whom may we contact in the case of an emergency? _____

Phone: _____

Whom may we thank for referring you to us? _____

Phone: _____

Did you sustain an injury at work?

Y N

Are you covered under an employer or union policy?

Y N

Are your injuries accident related?

Y N

Is your spouse or other family member employed?

Y N

Are you currently employed

Y N

Do you have a secondary insurance policy?

Y N

Have you ever served in the military?

Y N

Are you covered under any other health care plan?

Y N

Have you made any changes to your choice of Medicare options in the last open enrollment period?

Y N

Are you enrolled in a Medicare Advantage Plan?

Y N

I am a new patient to this practice and am in a pre-existing provision with my insurance carrier.

Y N

Who is responsible for this bill? _____

I have received services by another provider for the condition for which I seek treatment today and I will promptly disclose any necessary information to my insurance carrier necessary to resolve any issues they may have. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

Name: _____

Signature:_____ Date: _____

Please be advised that under the Health Insurance Portability and Accountability Act (HIPAA), all Intake Form information will be held confidential, protected and never shared unless by the exclusive and direct consent by the treated patient. In the event that medical information must be shared exclusively with clinical/administrative professionals for the purposes of patient's treatment, he/she will be notified prior to sending.

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Assignment of Benefits Form

Practice Name: _____ Date: _____

Address: _____ Patient: _____

City, State, Zip: _____ ID#: _____

Phone: _____ Group#: _____

I, _____, understand that services rendered to me by **Albatross Physical Therapy and Wellness** are my financial responsibility and that the provider will bill my insurance company _____, as a courtesy. I authorize my insurance company to pay my benefits directly to **Albatross Physical Therapy and Wellness** and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee and I haves agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

I have been given the opportunity to pay my estimated deductible and coinsurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by _____(insurance company).

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to **Albatross Physical Therapy and Wellness** within 48 hours. I agree that if I fail to

send the payment to **Albatross Physical Therapy and Wellness** and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event patient receives any check, draft or other payment subject to this agreement, I will immediately deliver said check, draft or payment to provider. Any violations of this agreement will, at provider's election, terminate patient charge privileges with provider and bring any balance owed by patient to provider immediately due and payable.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize **Albatross Physical Therapy and Wellness** to facilitate payment utilizing the credit card number on file to resolve the balance. A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize **Albatross Physical Therapy and Wellness** to initiate a complaint or file appeal to the insurance commissioner or any payer authority for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

Dated_____Witness _____

_____ _____

Signature of policyholder Patient or Guardian

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Credit Card on File Authorization Notice

Dear Patient,

We understand that convenience is not often associated with today's health-care environment. Our practice not only focuses on excellent health care service but also how to provide service as cost and time effectively as possible. We have found that collecting all known liability at the time of service is not only beneficial for the practice, but experience has proven that our patients appreciate knowing they will not have to worry about delayed billing or payments.

We provide secured methods of accepting your payment at the time of treatment and for keeping your credit card on file to handle any remaining balance after insurance company reimbursement. We will work with you in establishing a payment schedule if necessary using this credit card authorization form.

I, _____ (Guarantor Name), authorize Albatross Physical Therapy and Wellness to keep my signature and credit card information on file and to charge my account for balances that remain unpaid sixty (60) days following the service not to exceed (Amount) per month (or frequency as outlined in our agreement).

I understand the provider is offering this as a courtesy and I may pay my balance in full at any time and cancel this agreement. I am authorizing the use of this card for:

Patient Name: _____

Cardholder Name: _____

Card Holder Address: _____

_____

Type of Credit Card:_____

Card Number:_____

Expiration Date:_____Security Code: _____

Signature:_____Date:_____

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