PATIENT INFORMATION

→ _____ _____/_____/_____

↑ *Last Name, First Name, Middle Initial* *Date of Birth*

_____ (_____)_____

Mailing Address City Zip Code *Area Code Home Phone*

_____ □ Female □ Male _____

Email Address *Marital Status*

_____ _____ _____

Primary Insurance ID # *Secondary Insurance ID #* *How did you hear about us?*

_____ _____

First & Last Name of Referring Physician *Area of Pain*

_____ _____ _____

Emergency Contact Name *Relationship* *Phone*

ACCIDENT INFORMATION

Is this visit the result of an injury? □ YES □ NO *If so, date of injury*: _____

Were you injured: □ *On the Job?* □ *Auto Accident* □ *Other*

(Please explain:) _____

_____

Responsible Insurance Company Address City Zip Code

_____ _____ _____

Name of Adjuster / Attorney *Phone* *Claim Number*

YOUR INSURANCE BENEFITS

Provided as a courtesy for you. It is ultimately your responsibility to be aware of your coverage. Please discuss any questions/concerns /changes with our Office Manager

*Your Primary Insurance Deductible is $*_____ □ *has been met* □ *has not been met*

*Your Secondary Insurance Deductible is $*_____ □ *has been met* □ *has not been met*

Once your deductible has been met, your insurance will pay _____

You are responsible for _____ *due at time of treatment.*

Your insurance allows _____ *visits / $ per year* _____ *Visits / $ used to date*

CANCELLATION POLICY: Three (3) No Shows or Cancellations w/o 24 hour notice (except in the event of medical emergency), patient will be assessed $50.00 cancellation fee, payable at subsequent visit.

HIPAA NOTIFICATION and CONSENT TO TREAT

I agree to assign all medical benefits for services provided, including Medicare & other government sponsored programs, private insurance & any other health plans to **Magnolia Physical Therapy**. I understand that I am financially responsible for all charges whether or not they are paid for by said insurance. I hereby authorize **Magnolia Physical Therapy** to release all information necessary to secure the payment of said benefits & that I have been informed of HIPAA regulations as posted in clinic. I under- stand that this assignment of benefits is irrevocable unless advised by me in advance. If any portion of therapy is denied, I give **Magnolia Physical Therapy** permission to act as my representative in appealing. I hereby consent to receive treatment from **Magnolia Physical Therapy** consistent with a Plan of Care authorized by my physician.

X_____ _____

↑Signature Date

For Office Use Only

_____ _____ _____ _____

Account # Therapist Name Onset Date SOC