BACK ON TRACK
PHYSICAL THERAPY

WWW.BACKONTRACKPT.ORG

Name: _____ DOB: _____

Parent Name **(If Minor)**: _____

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

Check ☐ for appointment reminders/communication: Circle: Text Voice message

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

☐ Email address: _____

Referring Physician: _____ Diagnosis: _____

Insurance Information

Primary: (Please Circle): BCBS Tricare Cigna W/C M-care M-aid Auto Other; _____ **Secondary:** _____

Primary ID: _____ **Secondary ID:** _____ **Co-Insureance:** _____ **Co-pay:** _____

CO-INSURANCE/ CO-PAYMENTS: If your insurance company requires that you pay a co-pay you will be responsible for this amount at the time of your appointment. For co-insurance we will bill you once we receive final determination from the insurance company, this amount will be due by you **upon receipt.** **Initials:_____**

DEDUCTIBLE: Many insurance policies have a deductible in varying amounts, requiring you to meet your deductible (as stated in your insurance policy) before any insurance benefits will be covered. In the event that you have not met your deductible at the time you start your treatment, you may wish to make payments each time you come to make this obligation more manageable for you. **Initials: _____**

AUTHORIZATION TO PAY BENEFITS: I hereby authorize payment directly to Back On Track Physical Therapy for all medical benefits for services rendered. I understand that I am financially responsible for any and all charges NOT COVERED by my insurance as well as any remaining deductible and coinsurance. **I will pay my co-payments at the time of service.** Any and all medical equipment prescribed by my physician or therapist, not covered by insurance, will be paid in full at the time of delivery. **In the event that I do not pay for charges billed to me, I will be responsible for all costs and attorney's fees related to collecting the charges.** **Initials: _____**

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Back On Track Physical Therapy to release any information acquired in the course of my examination and/or treatment to my insurance company, physician, and employer (for Workers' Compensation only). **Initials: _____**

TREAT A MINOR: I hereby authorize Back On Track Physical Therapy to render Physical Therapy to my child (under age 18). **Initials: _____**

PATIENT RESPONSIBILITY INFORMATION: All insurance policies are different and therefore everyone's coverage is different. It is **your** responsibility to find out how much your policy covers, both in terms of number of visits and cost. You are responsible for payment of anything insurance doesn't cover. **Initials: _____**

CANCELLATION POLICY: Your recovery is a team effort between you and your therapist(s). Your therapist will design an individualized home program and plan of care for you based on your needs. **We require at least 24 hours' notice if you need to cancel your appointment**, you will be responsible for the cost for the scheduled visit if notice is not given. Our policy is to discontinue service if you fail to show or cancel an appointment without notice. **Initials: _____**

PRIVACY PRACTICES/HIPPA

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

I have read and understand the above. **Initials: _____**

Name (Print): _____ **Signature:** _____ **Date:** _____