



## ADMISSION FORM

MR Number: \_\_\_\_\_

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_

Date Injured: \_\_\_\_\_

Address: \_\_\_\_\_

SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: ☐ M ☐ F

Home Ph#: \_\_\_\_\_ Work Ph#: \_\_\_\_\_

Cell Ph#: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Workers Comp: ☐ Y ☐ N

Employer Address: \_\_\_\_\_

Auto Accident: ☐ Y ☐ N

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Have you received physical therapy at other locations this year? ☐ Y ☐ N

### PERSON WHO SIGNS CONSENT AND IS RESPONSIBLE FOR BILL

☐ SELF

Insured (Responsible) Party Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_-\_\_\_\_-\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph#: \_\_\_\_\_ Work Ph#: \_\_\_\_\_

Employer Name: \_\_\_\_\_

### PHYSICIAN INFORMATION

Referring MD: \_\_\_\_\_ Phone #: \_\_\_\_\_ Primary Care MD: \_\_\_\_\_ Return to MD: \_\_\_\_\_

### INSURANCE INFORMATION

*If you are being seen for an injury related to work comp or an automobile accident, please give us the name of your workers compensation/automobile carrier instead of your primary personal medical insurance carrier.*

Primary Insurance: \_\_\_\_\_ ID#: \_\_\_\_\_ Group #: \_\_\_\_\_ Ph#: \_\_\_\_\_

Pt. Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Do you have Secondary Insurance? ☐ Yes ☐ No If so Insurance Name: \_\_\_\_\_

Adjuster: \_\_\_\_\_ Claim #: \_\_\_\_\_ Is your case in litigation? ☐ Yes ☐ No

Attorney's Name: \_\_\_\_\_

### EMERGENCY CONTACT

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

I authorize the release of any private health information necessary to process this claim and to the emergency contact person listed above as needed.

I, the undersigned, agree whether signing as agent or as patient, that in consideration of the services rendered to the patient, to be individually obligated to pay the bill. Should the account be referred to an attorney for collection, I shall pay reasonable attorney's fees.

I hereby assign payment directly to Turning Point Therapies, **BASIC BENEFITS** and/or **MAJOR MEDICAL** (catastrophe) **BENEFITS** herein specified and otherwise payable to me, but not to exceed the regular charges for this period of treatment. I understand I am financially responsible for any charges not covered by this assignment.

I understand that upon discharge I may request, in writing, a copy of my records I have read, understand and signed the Turning Point Therapies Financial Policy

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_

### Consent for Treatment

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient at Turning Point Therapies. I also understand that Turning Point Therapies may use my patient treatment data for quality assurance and research purposes, and that my name or identity will not be connected with the data.

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_

## ADMISSION FORM OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our *Financial Policy* that we require you to read and sign prior to any treatment.

All patients must complete out *Information and Insurance Form* before seeing the therapist.

### REGARDING INSURANCE

We will gladly bill your insurance company directly if you have provided us with all the necessary information to do so on a bi-weekly basis. Your contract for health insurance is between you and your insurance company. We are not a party to that contract. The physical therapy services that you receive and the bill, is an agreement between you and ProActive Physical Therapy. **It is ultimately your responsibility to see that your physical therapy bill is paid in full.**

Agreements with the insurance companies vary greatly and it is your responsibility to know what their portion is and what is yours. Any remaining money unpaid by your insurance company will be your responsibility to pay in a timely manner. If your insurance company does not begin paying Turning Point Therapies within 5 weeks, it will be your responsibility to contact them. You will be notified by mail of the balance due on your account, and you may request a statement of account if necessary. It will reflect what your insurance company, upon verification, told us is your portion to pay. We expect this payment within 15 days. If payment is not received within this 15-day period, a finance charge of 1.5% will be assessed per month. In the event a check is returned for any reason, a \$20.00 charge will be made to your account.

### REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER

All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

If you receive payment made out to both Turning Point Therapies and you, please endorse the check and forward to us.

### USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances.

### ADULT AND MINOR PATIENTS

Adult patients are responsible for full payment at the time of service. The parents (or guardians) accompanying a minor are responsible for full payment of the minor's treatment. For unaccompanied minors, non-emergency treatment will be denied unless charges are paid by cash or check at the time of service.

### MISSED APPOINTMENTS

**Because we commonly have a waiting list, unless cancelled at least 8 hours in advance, our policy is to charge for missed appointments. The charge is \$25.00 for the first missed appointment and \$50.00 for the second missed appointment and \$75.00 for each subsequent missed appointment. Insurance does not pay this charge. You are responsible. Please help us serve you better by keeping scheduled appointments, or call us to cancel, in a timely manner to allow another patient to have your scheduled time.**

I have read the *Financial Policy*. I understand and agree to this *Financial Policy*.

### HIPAA

I acknowledge the receipt of Turning Point Therapies *HIPAA NOTICE OF PRIVACY PRACTICES*.

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_

Is there anyone involved in your care, or payment of your care with which we may share your medical information?

☐ Yes ☐ No If yes, person's name: \_\_\_\_\_ Relationship: \_\_\_\_\_

## PATIENT CANCELLATION AND “NO SHOW” POLICY

---

*Your scheduled appointment is a specific time when your therapist will spend time with you. It is extremely important to be timely.*

---

### FOR PHYSICAL THERAPY SERVICES

If you are unable to attend, **YOU MUST NOTIFY THE CLINIC AT LEAST 24 HOURS IN ADVANCE AND RESCHEDULE TO MAKE UP THE MISSED APPOINTMENT.** Failure to attend your sessions may hinder your recovery process as well as disrupt the schedule of your therapist.

Cancellation or failure to attend three consecutive appointments will result in termination of your therapy program. To restart your therapy you must return to your physician for a new prescription and obtain additional authorization from your insurance company.

### Workers Compensation Patients

In the event that you are covered by workers' compensation and fail to keep the appointments as recommended by your physician, the appropriate parties **WILL BE NOTIFIED OF YOUR ABSENCE IN WRITING.** Typically, the notification will be to your physician, insurance carrier, and employer and rehabilitation consultant. Each cancelled and “no show” appointment will also be noted in your chart. Please understand that failure to actively participate in your rehabilitation program may result in the impression that you are disinterested in your recovery or are better and able to return to work. Failure to attend therapy may have a negative effect on your workers' compensation coverage.

---

### FEES

- A fee of \$50.00 may be charged if you do not show for your appointment or do give us a 24 hour notice to cancel.

WE THANK YOU FOR RESPECTING THIS POLICY.

**I, the undersigned, understand the *Patient Cancellation and No show Policy* described above.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date