



FERNLEY PHYSICAL THERAPY

PATIENT INFORMATION

PATIENT'S FULL NAME (FIRST, MI, LAST)													
SOCIAL SECURITY NUMBER					DATE OF BIRTH				GENDER		M	F	
MAILING ADDRESS					CITY				ZIP				
HOME PHONE					CELL				MARITAL STATUS		S	M	OTHER
EMPLOYMENT STATUS		STUDENT	EMPLOYED		FT	PT	RET	IF EMPLOYED, OCCUPATION					
EMPLOYER							PHONE NUMBER						
REFERRING PHYSICIAN							PRIMARY CARE DOCTOR						
IS THE INJURY ACCIDENT RELATED?		Y	N	IF YES	AUTO	WORK	DATE OF INJURY				OTHER		
EMERGENCY CONTACT							PHONE:						
							RELATIONSHIP:						
ARE YOU RECEIVING HOME HEALTH SERVICES AT PRESENT?							YES		NO				
HAVE YOU RECEIVED ANY PHYSICAL THERAPY SERVICES THIS CALENDAR YEAR?				Y	N	IF YES, WHERE?							
						WHEN?							
PRIMARY INSURANCE INFORMATION													
INSURANCE COMPANY													
POLICY HOLDER'S NAME (Name as it appears on the card)							RELATIONSHIP TO PATIENT:						
							DOB:						
ID NUMBER					GROUP NUMBER					CLAIM NO: WORKERS COMP			

SECONDARY INSURANCE

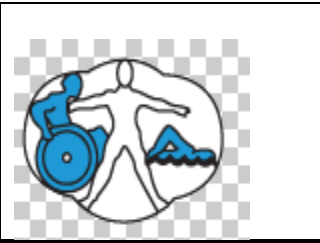
INSURANCE COMPANY			
POLICY HOLDER (Name as it appears on card)		DOB	
ID NUMBER		GROUP NUMBER	
POLICY HOLDER'S SSN			

HIPAA COMPLIANCE

I ACKNOWLEDGE THAT I HAVE BEEN OFFERED A COPY OF FERNLEY PHYSICAL THERAPY'S NOTICE OF PRIVACY PRACTICES AND I CONFIRM THAT ALL THE INFORMATION PROVIDED ON THIS FORM IS CORRECT.

PRINT NAME: _____

PATIENT/ GUARDIAN SIGNATURE _____ DATE _____



**FERNLEY PHYSICAL THERAPY
ASSIGNMENT OF BENEFITS AND
ACKNOWLEDGEMENT OF FINANCIAL POLICY**

ASSIGNMENT OF INSURANCE BENEFITS

I HEREBY ASSIGN ALL INSURANCE BENEFITS TO WHICH I AM ENTITLED TO FERNLEY PHYSICAL THERAPY, INC. I HEREBY AUTHORIZE MY INSURANCE CARRIER/S, INCLUDING MEDICARE, PRIVATE INSURANCE AND ANY OTHER HEALTH/MEDICAL PLAN TO ISSUE PAYMENT CHECKS/ELECTRONIC TRANSFERS DIRECTLY TO FERNLEY PHYSICAL THERAPY, INC. I UNDERSTAND AND ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCES. I UNDERSTAND THAT FERNLEY PHYSICAL THERAPY WILL BILL THE INSURANCES LISTED ON THE PATIENT INFORMATION SHEET. IF THE CLAIMS ARE NOT PAID DUE TO INACCURATE INFORMATION PROVIDED BY ME, I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY OUTSTANDING CHARGES.

INITIAL _____

ACKNOWLEDGEMENT OF THE FINANCIAL POLICY OF FERNLEY PHYSICAL THERAPY, INC.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO ADVISE FERNLEY PHYSICAL THERAPY OF ANY CHANGES TO MY MEDICAL INSURANCE. IF I FAIL TO DO THIS, I UNDERSTAND AND ACKNOWLEDGE THAT I WILL BE FINANCIALLY RESPONSIBLE FOR ANY OUTSTANDING CHARGES FOR SERVICES RECEIVED. I ALSO ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ANY CO-PAYMENTS, CHARGES THAT THE INSURANCE COMPANY ALLOCATES TOWARD MY DEDUCTIBLE AND ANY CO-INSURANCE AMOUNT. I UNDERSTAND THAT I AM RESPONSIBLE FOR KEEPING MY ACCOUNT CURRENT AND THAT IF MY ACCOUNT BECOMES PAST DUE, FERNLEY PHYSICAL THERAPY RESERVES THE RIGHT TO TURN THE ACCOUNT OVER TO A COLLECTION AGENCY. I ALSO ACKNOWLEDGE THAT FERNLEY PHYSICAL THERAPY RESERVES THE RIGHT TO PASS ANY COLLECTION FEES THEY INCURR ON TO ME FOR PAYMENT.

INITIAL _____

WORKMAN'S COMPENSATION PATIENTS ONLY

I UNDERSTAND THAT FERNLEY PHYSICAL THERAPY WILL OBTAIN THE REQUIRED AUTHORIZATIONS FROM THE APPLICABLE INSURANCE COMPANY. I UNDERSTAND THAT IF MY CLAIM IS DENIED AT ANY TIME DURING MY TREATMENT, I AM RESPONSIBLE FOR ANY CHARGES FOR SERVICES RECEIVED, UNTIL I PROVIDE ALTERNATIVE MEDICAL INSURANCE INFORMATION. IF I DO NOT PROVIDE THIS INFORMATION, I UNDERSTAND THAT THE TERMS OF FERNLEY PHYSICAL THERAPY'S FINANCIAL POLICY WILL BE APPLIED TO MY OUTSTANDING CHARGES.

INITIAL _____

I HEREBY ACKNOWLEDGE THAT I HAVE READ AND THAT I UNDERSTAND THE ABOVE POLICIES AND ASSIGNMENT OF BENEFITS.

PRINT NAME:

SIGNATURE: _____ DATE _____



**FERNLEY PHYSICAL THERAPY
AUTHORIZATION FOR THE RELEASE OF PROTECTED
HEALTH INFORMATION**

NAME: _____

I HEREBY GIVE FERNLEY PHYSICAL THERAPY, INC. PERMISSION TO DISCLOSE AND DISCUSS ANY INFORMATION RELATED TO MY TREATMENT TO THE FOLLOWING INDIVIDUALS:

NAME _____ RELATIONSHIP _____

NAME _____ RELATIONSHIP _____

APPOINTMENT REMINDERS:

TEXT MESSAGE	YES	NO	CELL NO	
E MAIL	YES	NO	EMAIL ADDRESS	

I HEREBY AUTHORIZE FERNLEY PHYSICAL THERAPY, INC., TO RELEASE ALL INFORMATION NECESSARY TO SECURE PAYMENT OF INSURANCE BENEFITS. I UNDERSTAND THAT THEY KEEP A RECORD OF HEALTH SERVICES PROVIDED TO ME AND THAT I MAY OBTAIN A COPY OF THESE RECORDS WITH THE UNDERSTANDING THAT A FEE MAY APPLY IF I REQUEST COPIES OF SAID RECORDS. I HEREBY AUTHORIZE THE RELEASE, TO FERNLEY PHYSICAL THERAPY, INC., OF ANY IMAGING REPORTS, DOCTOR'S NOTES OR ANY OTHER MEDICAL RECORDS THAT ARE RELATED TO THE PHYSICAL THERAPY TREATMENTS GIVEN TO ME.
THIS AUTHORIZATION IS VALID FOR ONE CALENDAR YEAR FROM THE DATE OF SIGNATURE.

SIGNATURE: _____ DATE: _____



FERNLEY PHYSICAL THERAPY

CANCELLATION POLICY

YOUR ADHERENCE TO THE RECOMMENDED FREQUENCY AND DURATION OF TREATMENTS IS A VITAL COMPONENT OF YOUR PROGRESS AND RECOVERY.

COMMITMENT TO APPOINTMENTS

YOUR RECOVERY DEPENDS ON ATTENDING ALL YOUR SCHEDULED APPOINTMENTS.

LATE POLICY

- ❖ PLEASE CALL TO ADVISE US IF YOU ARE RUNNING LATE.
- ❖ IF YOU ARE MORE THAN 10 MINS LATE, WE WILL RESCHEDULE YOUR APPOINTMENT.

NO SHOW POLICY

- ❖ IF YOU MISS A SCHEDULED APPOINTMENT AND DO NOT CONTACT US, WE WILL CHARGE A \$50 NO SHOW FEE.
- ❖ IF YOU MISS MORE THAN 2 APPOINTMENTS IN A ROW, WE WILL CANCEL ALL FUTURE SCHEDULED APPOINTMENTS.

CANCELLATION POLICY

- ❖ WE REQUIRE 24 HOURS NOTICE IF YOU NEED TO CANCEL AN APPOINTMENT.
- ❖ IF WE DO NOT RECEIVE 24 HOURS NOTICE WE WILL CHARGE A \$40 CANCELLATION FEE.

PAYMENT OF CANCEL AND NO-SHOW FEES

THESE CAN NOT BE BILLED TO YOUR INSURANCE COMPANY. ANY FEE THAT WE MAY CHARGE YOU IS YOUR RESPONSIBILITY.

I HAVE READ AND I UNDERSTAND FERNLEY PHYSICAL THERAPY'S CANCELLATION AND NO-SHOW POLICY. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR THE PAYMENT OF ANY LATE, CANCELLATION OR NO SHOW FEES THAT MAY BE CHARGED TO MY ACCOUNT.

SIGNATURE _____ DATE _____