Precision Physical Therapy, Inc.

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Louisville, CO 80027

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Arvada, CO 80005

www.precisionphysicaltherapy.net

303-926-1444 (phone) 303-926-0038 (fax)

Patient Information

Full Name:	DOB: ___/___/_____	SSN:
Address:	City/State:	Zip:
Phone: (home)	(cell)	(work)
Email Address:		Sex: M/F
Referred by:	Referring Physician Phone:	
Address:	City/State:	Zip:
Primary Care Doctor:	Office Phone:	
Address:	City/State:	Zip:
Emergency Contact Info	Name:	Contact Number:

Primary Insurance

Primary Insurance Plan:	Policy Holder Name:
ID Number:	Relationship to Patient:
Group Number:	Policy Holder Date of Birth:

Secondary Insurance

Secondary Insurance Plan:	Policy Holder Name:
ID Number:	Relationship to Patient:
Group Number:	Policy Holder Date of Birth:

Condition Information

Is your condition due to an accident?	Date of Accident:	
Type of Accident: Auto/Work/Home	If other, please qualify:	
Did you file a claim? Y/N	Adjuster's Name: Claim #:	Adjuster's Contact Number:

Patient Name:	Date of Birth:

Acknowledgement of receipt of notice of Privacy Practices

I acknowledge that I have been offered or provided a copy of *Precision Physical Therapy* Notice of Privacy Practices.

Consent to Treat

I authorize *Precision Physical Therapy* to render services as deemed necessary for the care of the above named Patient.

For Minors Only:
I **do** [ ] / **do not** [ ] allow the above named Patient to be treated by *Precision Physical Therapy* without a Guardian being present.
Responsible Party Name: ____________________ Responsible Party Signature: _____________________

HIPAA Medical Information Release

Release of Information:

I authorize the release of information from *Precision Physical Therapy* including the diagnosis, records, examination rendered to me and claims/billing information. This information may be released to:

[ ] Spouse ____
[ ] Child(ren) _____________________________________
[ ] Doctor(s) ______________________________________
[ ] Other ____
[ ] Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Your signature below indicates:

1. You read and understand the Acknowledgement of receipt of Notice of Privacy Practices
2. You understand and agree to the Consent to Treat
3. You read and understand the Medical Information Release.

Patient or Responsible Party Signature:	Date Signed:
(Responsible Party, Relationship to patient):	

Patient Name:	Date of Birth:

Assignment of Medical Insurance Benefits

Thank you for choosing *Precision Physical Therapy*. We will work with you to help you with your insurance claims, but would like you to understand our office policy regarding insurance assignment.
Payment is expected at the time of service unless we accept assignment with your insurance company or previous payment arrangements have been made. For our office to accept insurance assignment, we ask that you read and sign the following.

I acknowledge that it is my responsibility to:

1. Provide complete up-to-date information on medical insurance coverage for the patient.
2. Present a valid insurance card when requested.
3. Pay applicable copayment at the time of service.
4. Present a valid referral or authorization number for all services (if required by my insurance company).
5. Inform the office if the patient's need for medical services is due to a motor vehicle, worker's compensation or other accident.
6. Make payment within 30 days any balance on my account for any amount due such as deductibles, coinsurance, co-payments, or non-covered services.

Payment Policy

I am ultimately responsible to pay the medical bill if my insurance company does not honor the assignment of benefits in whole or in part. Payments may be arranged. I agree that if it becomes necessary to forward my account to a collection agency, I will also be responsible for the reasonable cost of collection, to include any attorney fees.

Your signature below indicates:

1. You understand and accept our policy of assignment of insurance benefits.
2. You attest to the accuracy and completeness of the medical insurance coverage information.
3. You authorize this office to release medical information necessary to process your claims and appeals.
4. You authorize payment of medical benefits to *Precision Physical Therapy*.
5. You have read and understand the Payment Policy.

Patient or Responsible Party Signature:	Date Signed:
(Responsible Party, Relationship to patient):	