North Lake Physical Therapy & Rehabilitation

PATIENT INFORMATION

Name:_____ Birth Date:_____/_____/_____
First MI Last

Address: _____
Street City State Zip

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

SS#:_____/_____/_____ Gender: M F Married: Y N Email: _____

Referring Physician: _____ Date Last Seen: _____ Emergency Contact/Number: _____

INSURANCE INFORMATION

☐ *Private/Personal Insurance* Insurance: _____

☐ *Medicare* Subscriber Name: _____ Date of Birth: ____/____/_____

☐ *Workman's Compensation* Group #: _____ ID#_____

☐ *Motor Vehicle Accident* Adjuster/Phone Number: _____

Claim Number: _____ Date of Injury/Accident: _____/_____/_____

HIPPA NOTIFICATION

I understand that North Lake Physical Therapy (referred to below as "the clinic") will use and disclose health information about me in the course of providing physical therapy for me. I understand that my health information may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar health related information. I understand that the clinic is permitted to use and disclose my health information in order to make decisions about and plan for my care and treatment; refer to/or consult and coordinate with other health care providers in the course of my treatment; determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and perform various office, administrative and business functions that support the clinic's ability to provide me with appropriate care and arrange for payment. I understand that Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request and that a copy or a summary of the most current version of the clinic's Notice of Privacy Practices in effect will be posted in the waiting/reception area. I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the clinic is not required by law to agree to such requests. By signing below, I agree that I have received or been offered a copy of this clinic's Notice of Privacy Practices.

I wish to be contacted in the following manner: (Check all that apply)

Leave Detailed Message: ☐ Home ☐ Work ☐ Cell **OR** Leave Call Back Number Only: ☐ Home ☐ Work ☐ Cell

Speak With Someone Regarding Your Account: ☐ Spouse ☐ Other: _____

North Lake Physical Therapy will bill your primary insurance. We do not bill secondary insurance carriers except Medicare patients. All charges are due and payable within 60 days from date of charge whether or not your insurance has paid their portion of charges. Patients not covered by insurance are asked to pay at the time of service. Patient or responsible party agrees that he/she is financially responsible for all unpaid charges and agrees to remit payment to the clinic when payment is due. The clinic accepts assignment from Medicare. We call on benefits as a courtesy to our patients. However, it is still your responsibility to know your benefits (co-pay, visit limits, etc.) Patients are responsible for obtaining required doctor's prescriptions or authorizations. Co-pays not made at time of treatment will be billed to you.

I hereby authorize North Lake Physical Therapy to furnish my insurance company all information which said insurance company may request concerning my present claim. I hereby assign to North Lake Physical Therapy all benefits to which I am entitled for expenses relative to the services performed.

Patient/Patient Representative Signature: _____ Date:_____/_____/_____