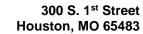




Phone: **(417) 967-0900** Fax: **(417) 967-0905** 

## **Patient Information Form**

Patient Information *				
Last Name		First name		MI
Address			Apt	•
City		_ State	Zip	
Home Phone	Cell Phone	9	Work Phone	
Date of Birth	SSN	Gender	Marital Status	3
Email	I	How did you hear abou	ıt us?	
Employer				
Name			Phone	
Address				
City				
Emergency Contact *				
Last Name		First name		MI
Relationship	Home Phone _		Cell Phone	
Problem *				
Major Complaint			_ When did it start	
Motor Vehicle Accident	Yes No	Date of Accident	State Occur	red
Open Auto Claim	Yes No	Claim #		
Work Place Injury	Yes No	Date of Injury		
Open Work Comp Claim	Yes No	Claim #		
Referring Physician *				
Name			_ Phone	
Primary Care Physician	*			
Name			_ Phone	
Primary Insurance				
Insurance			_ ID #	
Subscriber Name			_ Date of Birth	
Secondary Insurance				
Insurance			_ ID #	
Subscriber Name			_ Date of Birth	
Tertiary Insurance				
Insurance			_ ID #	
Subscriber Name			_ Date of Birth	
Disputes regarding benefits are betw charges are ultimately the responsibil My representative or I, recognizing the	lity of the patient.			·
Signature*:			Date*·	





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Physical therapy services often require multiple visits to be effective and benefits for these services may be different than those paid by your insurance plan for other types of services. As a courtesy, Advanced Care Physical Therapy will file claims with you **primary** (only) insurance plan, contingent on the following:

- 1. Your insurance company confirms, when contacted by our office, that outpatient physical therapy services are a covered expense under your plan. \*
- 2. Any deductible not met for your current plan year, <u>as stated by your insurance company at the time of our contact with them</u>, be paid in full at the time of each visit until the deductible is satisfied. Once the deductible is met, you will be responsible for only the estimated uninsured portion of your treatment. All payments are due at the time of each visit.
- 3. All supplies/equipment must be paid for at the time of receipt. We can provide you with a statement to submit to your insurance company to see reimbursement if you would like.

Advanced Care Physical Therapy is a network provider for many insurance plans. If you are covered by an insurance plan that we contract with, your account will be handled per your plan's benefits, as relayed to our office by your carrier. Our office will make every reasonable effort to contact your insurance company for benefit information prior to your initial visit, when possible, and will handle your account accordingly. **However**, please be aware that identifying these benefits is not a guarantee of payment by your insurance company. All benefits and claims are subject to the terms and provisions of your contract or policy limitations and exclusions (including preexisting condition limitations and your current eligibility for benefits), and are contingent on continual payment of premiums by yourself, the insured, and/or your plan sponsor. Final determination of benefit payments will only be made when the claim is actually received and processed by your insurance plan.

Advanced Care Physical Therapy cannot accept financial responsibility or liability for inaccurate, incomplete, or otherwise incorrect information provided to our office by your insurance plan, or by the patient and/or insured who provides information on your coverage to our office. As such, we strongly urge you to contact your insurance carrier (and review your benefits information) to advise of your anticipated physical therapy treatment, and to verify your outpatient physical therapy benefits.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ THE FOREGOING AND IS THE PATIENT, THE PATIENT'S AGENT, INSURED AND/OR GUARANTOR, AND ACCEPTS ALL TERMS INSURED AND/OR GUARANTOR HAS SIGNED A "CONSENT OF DISCLOSURE" AND HAS ALSO BEEN GIVEN THE OPPORTUNITY TO READ ADVANCED CARE PHYSICAL THERAPY PRIVACY POLICIES, AND IS ENTITLED TO A COPY OF EITHER OR BOTH UPON REQUEST.

Insured and/or Guarantor	Date	
Witness	Date	