ADVANCED CARE
Physical Therapy

300 S. 1st Street
Houston, MO 65483

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 _____ Work Phone _____

Date of Birth _____ SSN _____-_____-_____ Gender _____ Marital Status _____

Email _____ How did you hear about us? _____

Employer

Name _____ Phone _____

Address _____

City _____ State _____ Zip _____

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 Occurred _____

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 between the patient and the insurance company. Notification of changes to insurance is the responsibility of the patient. All charges are ultimately the responsibility of the patient.

My representative or I, recognizing the need for care, consent to all services ordered or deemed appropriate by my physician and/or physical therapist.

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, **as stated by your insurance company at the time of our contact with them,** 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