**PATIENT INFORMATION**

|  |
| --- |
| **Patient Name:** |
| **DOB:** | Age: |
| **Primary Phone:** |
| **Body Part:** |
| **Referring Physician or Other Referral:** |
| Email: |
| Address:City, State, Zip: |
| Emergency Contact/Phone: |
| Have you had PT since January 1st of this year? |

**IF PATIENT IS UNDER 18 PLEASE FILL OUT BELOW**

|  |  |
| --- | --- |
| Guarantor/Parent Name: | DOB: |
| Address: |
| Primary Phone: |

**WORKER’S COMPENSATION PATIENT FILL OUT BELOW**

|  |  |
| --- | --- |
| Employer Name: | Primary Phone: |
| Address: | Social Security: |

**FOR OFFICE USE ONLY**

**PRIMARY INSURANCE**

|  |
| --- |
| Insurance Name: |
| Policy ID/Claim Number: |

**SECONDARY INSURANCE**

|  |
| --- |
| Insurance Name: |
| Policy ID/Claim Number: |

**Authoriztion Y/N Deductible­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_Copay/Co-ins\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Visit Limit\_\_\_\_\_\_\_\_\_\_**

**\***Disclaimer: While every attempt is made to provide up-to-date information, Active Physical Therapy does not ensure the accuracy of the information provided. Since medical or health insurance reimbursement is affected by many factors, Active Physical Therapy cannot guarantee that a patient will be successful in obtaining insurance reimbursement.

Yes, I want APT to bill my insurance No, I do NOT want APT to bill my insurance

\*Please note, if you choose to not have us bill your insurance, **we will not be able to bill at a later date.**

**AGREEMENT TO BILL INSURANCE:**

I do hereby authorize Active Physical Therapy to submit claims to my insurance company/companies on my behalf. **I understand I am responsible for any deductible, co-payment, and other amounts not covered by my insurance. In the event my insurance does not cover services provided, I will assume the responsibility for the payment**. I request that payment pf authorized Medicare/Insurance Company benefits made to Active Physical Therapy for any services furnished me by that party who accepts assignment/physician. All regulations pertaining to Medicare assignment of benefits apply. **Patients are responsible for all deductible, co-insurance, and non-covered services, which is the charge determination of your insurance company.**

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PATIENT/GUARDIAN SIGNATURE DATE