



**PHYSICAL THERAPY PLUS  
NEW PATIENT INFORMATION**

**\*\*\*No P.O. Box Addresses\*\*\***

**Client Information:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Employer: \_\_\_\_\_ **SSN:** \_\_\_\_\_

Email Address: \_\_\_\_\_

Your Referring MD: \_\_\_\_\_ Your Family MD \_\_\_\_\_

Date of your injury or surgery: \_\_\_\_\_ Was your injury due to:  Auto Accident  Work Injury  Other

Have you had Physical Therapy Before? Y N If yes, when? \_\_\_\_\_ How long? \_\_\_\_\_

**Responsible Party Information** (Please fill out if client is minor)

Name: \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**POLICY HOLDER INFORMATION:**

Insurance Company: \_\_\_\_\_ Insurance ID # \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Policy Holder Date of Birth: \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_ Policy Holders SSN \_\_\_\_\_

Policy Holder address if different than client: \_\_\_\_\_

Client relationship to insured (please circle one):  Self  Spouse  Child  Other

**Secondary Insurance:**

Insurance Company: \_\_\_\_\_ Insurance ID # \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ Policy Holder Date of Birth \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_ Policy Holders SSN \_\_\_\_\_

Policy Holder address if different than client: \_\_\_\_\_

Client relationship to insured (please circle one):  Self  Spouse  Child  Other

**How did you hear about us?** (check one)

Physician

Telephone book

PT Plus Newsletter

Friend/Relative

Newspaper

Website

Other: \_\_\_\_\_

**\*\*PLEASE RETURN THIS FORM WITH INSURANCE CARD AND PICTURE ID\*\***

Employee initial \_\_\_\_\_



**Physical Therapy Plus  
Fees and Collections Policy**

I understand that I am fully responsible for payment of services rendered to me, by the above practice, before the session begins. I realize that my Physical Therapy benefits have been determined prior to this appointment and it is company policy to collect all co-payments, co-insurance, and deductible payments before each visit. I understand that I am financially responsible for charges not covered by my insurance and agree to guarantee payment for any balance due. **Any unpaid balance after 90 days will be subject to 7% interest.**

**No-Show/Late Cancellation Fees**

A fee of **\$25.00** will be added to the account of any patient failing to cancel an appointment 12 hours prior to appointment time. A patient is considered a "no-show" if the appointment is not kept and not canceled 12 hours prior to the scheduled time. These charges are not covered by health insurance benefits and are the responsibility of the patient/responsible party. Patients with no-show fees must clear the charge prior to the next scheduled appointment.

**Miscellaneous**

Requests for medical records: The patient will receive 1 free copy of their medical records. Additional requests are \$1.00 per page plus postage and handling fees.

**Collection Procedures**

Our office reserves the right to place all accounts 30 days past due into collection procedures.

**Returned Checks**

There is a \$35 fee for checks returned for insufficient funds. The patient will then be required to use cash, money order, or credit card for all future transactions. A letter will be mailed, giving the patient 10 days to redeem the check in cash or money order. After 10 days, the check will be handed over to the County Attorney's Office for collection.

I have read, understand and agree to the above policy.

\_\_\_\_\_  
Patient or Parent/Guardian Signature

\_\_\_\_\_  
Date

Employee Initial \_\_\_\_\_