Belmont Shore
PHYSICAL THERAPY

Patient Information

Patient Name:	Home Phone:
Date of Birth:	Work Phone:
Street Address:	Cell Phone:
City, State, Zip:	Soc. Sec.#:
Physician Name:	Marital Status:
Employer:	
Occupation:	
Business Address:	
City, State, Zip:	

Responsible Party

Name:	Date of Birth:
Phone:	Soc. Sec.#:
Relationship to Patient:	

Emergency Contact Information

Name:	Relationship:
Phone:	

Insurance Information

Are we treating you for an injury that occurred at your place of employment or due to a motor vehicle accident? Yes □ No □

Primary Insurance:
Secondary Insurance:

Initial: _____ **Date:** _____

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Patient Reimbursement Agreement

As a courtesy to our patients, we will contact your insurance carrier to obtain your physical therapy benefits. However, we are not accountable for the accuracy of the information provided. It is your responsibility to contact your insurance carrier to understand and confirm benefits and charges for services rendered.

If your insurance carrier fails to pay for services within 90 days, you will be billed for all unpaid charges which are due within 30 days. Failure to pay your balance will result in collection agency assignment.

At the time of service, you are responsible for payment of your annual deductible and co-payments/coinsurance.

Cancellation, No Show and Late Policy

As a courtesy to our staff and patients, **please contact our office to cancel at least 24 hours in advance of your scheduled appointment time. Without proper notification, a fee of $ 25.00 will be charged.**

3 Consecutive cancellations or no show results in automatic discharge from physical therapy services.

At Belmont Shore Physical Therapy we emphasize personal attention and treatment to meet your needs. A missed appointment also interrupts your rehabilitation program, and in partnership, we become less effective in reaching your goals and goals of your referring physician. If you are late for an appointment, you will be seen for the remainder of your scheduled time so that we do not inconvenience other patients.

Please sign below that you read and understand the above policy.

Signature: _____ **Date:** _____

Signature of Parent/Guardian: _____ **Date:** _____

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Consent to Physical Therapy /Rehabilitation Services and Direct Access:

I have presented myself for rehabilitation services to Belmont Shore Physical Therapy and consent to examination and treatment provided by my attending physical therapist. I consent to the release of copies of my examination/treatment records to referring physician(s), and third party payer (insurance companies) for the sole purpose of communication and claims processing. Also, I consent to release my medical records to an attorney and/or court order upon request. All medical records will have a printing charge and clerical fee. I authorize Belmont Shore Physical Therapy to make inquiries as it determines necessary to confirm my coverage and my financial responsibility.

I understand that I am receiving direct physical therapy treatment services and may continue to receive direct physical therapy treatment services for a period of up to 45 calendar days or 12 visits, whichever occurs first, after which time a physical therapist may continue providing me with physical therapy treatment services only after receiving, a dated signature on the physical therapist's plan of care indicating approval by the physician and surgeon or podiatrist.

Signature: _____ **Date:** _____

Signature of Parent/Guardian: _____ **Date:** _____