

# WELCOME TO TWIN RIVERS PHYSICAL THERAPY, PC

Acct# \_\_\_\_\_

Referring Dr: \_\_\_\_\_

DATE: \_\_\_\_\_

Date of Rx: \_\_\_\_\_

NAME \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
(last) (first) (mi)

CELL PHONE \_\_\_\_\_

NICK  
NAME: \_\_\_\_\_

ADDRESS \_\_\_\_\_  
(street) (city) (state) (zip)

SEX \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ SOCIAL SECURITY# \_\_\_\_\_

PATIENT'S EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_

SPOUSE'S NAME \_\_\_\_\_ SPOUSE'S BIRTHDATE \_\_\_\_\_

SPOUSE'S EMPLOYER \_\_\_\_\_ WORK PHONE \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_

FAMILY DOCTOR \_\_\_\_\_  
(name) (city)

IS YOUR CONDITION RELATED TO AN AUTO ACCIDENT, WORK INJURY OR OTHER LIABILITY  
ACCIDENT? YES \_\_\_\_\_ NO \_\_\_\_\_ INJURY DATE \_\_\_\_\_

## PLEASE CHECK ALL ACCEPTABLE CONTACT OPTIONS:

Call your home # and/or cell # and leave a message \_\_\_\_\_

Leave a message with your spouse/child \_\_\_\_\_ Call your work # and leave a message on your voice mail \_\_\_\_\_

## \*COMPLETE THIS SECTION IF PATIENT IS A MINOR

NAME OF PARENT OR GUARDIAN \_\_\_\_\_

RELATIONSHIP \_\_\_\_\_ HOME PHONE \_\_\_\_\_

(OVER)

**A COPY OF YOUR INSURANCE CARD(S) IS REQUIRED FOR INSURANCE CLAIM  
SUBMISSION, UNLESS WORKER'S COMP OR OTHER PERSONAL LIABILITY**

PRIMARY INSURANCE COMPANY \_\_\_\_\_  
NAME OF INSURED \_\_\_\_\_ ID # \_\_\_\_\_

SECONDARY INSURANCE COMPANY \_\_\_\_\_  
NAME OF INSURED \_\_\_\_\_ ID # \_\_\_\_\_

**CANCELLATION POLICY:** We understand that circumstances arise that make it necessary to cancel your appointment on short notice. A 24 hour notice is appreciated for cancellation of an appointment whenever possible so the time slot may be utilized for other patients. Two (2) or more cancellations/no shows without 24 hour notice will be subject to a \$25 service fee that is not billable to your insurance company. Thank you for your cooperation in this matter.

**AUTHORIZATION FOR TREATMENT/RELEASE OF INFORMATION:** I consent to the provision of care rendered by therapists of Twin Rivers Physical Therapy, PC (TRPT). I authorize TRPT and any therapist who treats me/the patient, to release to its authorized billing agents or billing agents of any of the third party payor or any other intermediaries responsible for payment of my/the patient's charges the following information: diagnosis and other necessary medical information via fax or other methods. I authorize provision of information concerning my care, condition and treatment for quality assurance/risk management purposes.

**ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize release of medical information necessary to process my Medicare/insurance claim and assign benefits directly to Twin Rivers Physical Therapy, PC. I understand I am responsible for charges not covered by this assignment.

**FINANCIAL AGREEMENT:** It is understood, whether I sign as agent, or as patient, or as 'Guarantor' that I am directly responsible and will pay for services rendered and not paid by insurance. I further understand a 1.5% service charge will accrue after 30 days on any unpaid balance on my account and if there is no activity made on my account for 6 months my account will be referred to a collection agency. Should the account be referred to collection, I (patient, agent and 'Guarantor') shall pay reasonable costs of collection including but not limited to attorney's fees and court costs incurred as a result of any suit or claim that may be filed in connection therewith. A copy of Twin Rivers Physical Therapy, PC Financial Policy is available upon request.

**A COPY OF THE HIPAA NOTICE OF PRIVACY PRACTICES THAT YOU HAVE SIGNED IS  
AVAILABLE UPON REQUEST.**

**I have read this form and understand its contents. I have had an opportunity to ask questions which  
have been answered to my satisfaction.**

**SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_**