

# SACO BAY ORTHOPAEDIC & SPORTS PHYSICAL THERAPY, PA

PT INITIALS	DX 1:	DX 2:	ACCT #:
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DATE \_\_\_\_\_

NAME (FIRST) \_\_\_\_\_ (LAST) \_\_\_\_\_ (MI) \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL \_\_\_\_\_ EMAIL \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_  M  F DATE OF BIRTH \_\_\_\_\_ AGE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

**STATUS**  SINGLE  MARRIED  OTHER **STUDENT**  FULL-TIME  PART-TIME

*NAME & ADDRESS OF RESPONSIBLE PARTY.* CHECK HERE  IF SAME AS ABOVE

NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

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

REFERRING PHYSICIAN \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

FAMILY PHYSICIAN (PCP) NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

INJURY DATE/ONSET OF PAIN \_\_\_\_\_ **INJURY TYPE:**  WORK  AUTO  HOME  OTHER

**PRIMARY INSURANCE**

PRIMARY INSURANCE COMPANY \_\_\_\_\_ ARE YOU THE POLICYHOLDER?  YES  NO

IF NO, PLEASE PROVIDE POLICYHOLDER INFORMATION BELOW:

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_ DOB \_\_\_\_\_

SSN \_\_\_\_\_ POLICY HOLDER'S EMPLOYER \_\_\_\_\_ RELATIONSHIP TO THE PATIENT \_\_\_\_\_

**SECONDARY INSURANCE**

SECONDARY INSURANCE COMPANY \_\_\_\_\_ ARE YOU THE POLICYHOLDER?  YES  NO

IF NO, PLEASE PROVIDE POLICYHOLDER INFORMATION BELOW:

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_ DOB \_\_\_\_\_

SSN \_\_\_\_\_ POLICY HOLDER'S EMPLOYER \_\_\_\_\_ RELATIONSHIP TO THE PATIENT \_\_\_\_\_

**OTHER INSURANCE:  WORKER'S COMPENSATION  MOTOR VEHICLE**

INSURANCE COMPANY \_\_\_\_\_ ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ CLAIM # \_\_\_\_\_ ADJUSTER'S NAME \_\_\_\_\_ PHONE \_\_\_\_\_

>>> **MEDICARE PATIENTS:** Are you currently having HOME HEALTH CARE from a HOME HEALTH AGENCY?  YES  NO

\*\*\*\*\* **MEDICARE HAS A YEARLY DOLLAR AMOUNT CAP ON OUTPATIENT PHYSICAL THERAPY** \*\*\*\*\*

**HAVE YOU HAD OUTPATIENT PHYSICAL THERAPY ANYWHERE ELSE THIS YEAR?**  YES  NO

As the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility.  
 I authorize Saco Bay Orthopaedic & Sports Physical Therapy, PA to obtain, in my behalf, any insurance information covered by "The Privacy Act" from my insurance company(s) file(s).  
 I understand that Saco Bay Physical Therapy has the Health Information Privacy and Accountability Act (HIPAA) available to me at any time and their Privacy Statement is posted in their office.  
 I authorize payment directly to the physical therapist for physical therapy benefits, which have not been paid by me.  
 I authorize the release and/or obtaining of any medical information necessary to provide care to me and/or complete and process this claim.  
 I understand that copays and/or balances due from applicable coinsurance are always due at the time of service.  
 I agree to provide a 24-hour notice of cancellation of an appointment. I agree to pay a \$25.00 "late cancellation" fee if this notification is not provided.  
 I understand that any information regarding physical therapy benefits is not a guarantee, but a quote from an insurance representative.

\_\_\_\_\_  
Signature of Patient/Legal Guardian

\_\_\_\_\_  
Date