Move Pain Free

Advanced Neuro & Orthopedic Physical Therapy, LLC

Patient Name First Middle Last			Date of Birth	Age
Home Address	Apt#	City	State	Zip Code
Occupation	Marital Status ___S___M___D___W		Sex	Home/Cell Phone
Employer		Address		Work Phone
Spouse/Parent's Name		Spouse/Parent's Employer		Work Phone
Spouse/Parent's Address				
Person to contact in case of Emergency		Relationship	Home Phone	Work Phone
Referring Physician		Address		Telephone No.

AUTHORIZATION TO RELEASE INFORMATION, PAYMENT REQUEST AND AUTHORIZATION TOPAY INSURANCE BENEFITS:

I hereby authorize payment directly to Advanced Neuro & Orthopedic Physical Therapy, LLC of all physical therapy related insurance benefits otherwise Payable to me, covering treatment by any physical therapist of this clinic. I understand that I am personally responsible to Advanced Neuro & Orthopedic Physical Therapy, LLC and all treating physical therapist for payment of all charges not paid in full by insurance coverage and that such charges must be paid by me within 30 days of the date displayed on my bill. Should Advanced Neuro & Orthopedic physical therapy, LLC refer my account to a collection agency and /or attorney for collection, I agree to pay all collection costs, including, but not limited to court costs, attorney's fees and any other legal related fees. I understand that all delinquent accounts shall bear interest at the rate of 20 percent per annum.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier, the physician's billing agent, family or private physician (or in the case of Medical Benefits, to the Social Security Administration and Health Care Financing Administration).

I understand that COPAY is determined by my insurance carrier and I am obligated to pay the full amount at the time of service.

I permit a copy of this authorization to be used in place of the original.

Insurance Non-Coverage Agreement: Medicare and other insurance carriers will pay only for services they determine to be "reasonable and necessary". Often you and your therapist believe that it is necessary to do something Medicare of your insurance may not agree to. Therefore, Advanced Neuro & Orthopedic physical Therapy is asking EVERYONE to sign an Insurance Non-Coverage Agreement. By signing this form, you are agreeing to be financially responsible for treatments that you and your Therapist determine to be appropriate. Thank you for your understanding and cooperation.

I have been informed that Medicare/other insurance will only pay for services that it determines to be "reasonable and necessary". I have been notified on the date indicated that Medicare/other insurance may deny payment for the treatments determined by me and my therapist to be appropriate. This expense will be billed to the insurance carrier in accordance with

their contractual agreement. I agree to pay for this service if the bill submitted to my insurance carrier is denied for reimbursement.

BENEFICIARY AGREEMENT: "I HAVE BEEN NOTIFIED BY MY THERAPIST THAT HE OR SHE BELIEVES THAT IN MY CASE MEDICARE IS LIKELY TO DENY PAYMENT FOR THE SERVICES IDENTIFIED ABOVE, FOR THE REASONS STATED IF MEDICARE DENIES PAYMENT, I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT:

REFERRAL RELEASE: I UNDERSTAND THAT IF MY INSURANCE COMPANY REQUIRES A REFERRAL AND/OR AUTHORIZATION FROM MY PRIMARY CARE PHYSICAN FOR ME TO BE SEEN BY ADVANCED NEURO & ORTHOPEDIC PHYSICAL THERAPY, LLC TODAY I MUST PROVIDE A SIGNED AND DATED ORIGINAL FORM AT THE TIME OF MY APPONTMENT. IF I AM UNABLE TO OBTAIN THE PROPER REFERRAL FORM AND/OR AUTHORIZATION FROM MY PRIMARY CARE PHYSICIAN I AGREE TO PAY IN FULL ALL SERVICES RENDERED.

Signed_____Dated_____

Area of Major complaint (Please indicate part of your body)	**Please circle Left or Right**
Date of injury or onset of symptoms	**Where and how did it happen?**
Name of Family Physician	**Address of Family Physician and phone #**

Have you ever had Physical therapy before? (YES or NO) If yes, what was the diagnosis and how many visits?

_____

Is your condition related to work? (YES or NO) If yes, have you filed a worker's compensation claim? (YES or NO)

_____

Is your condition related to an auto accident? (YES or NO)

_____

OTHER MEDICAL PROBLEMS:

_____Heart Disease _____Lung Disease

_____High Blood Pressure _____Cancer

_____Diabetes ____Other_____

OTHER MAJOR SURGERIES IN THE PAST 5 YEARS

_____

_____

_____

LIST MEDICATIONS YOU ARE CURRENTLY TAKING

_____

_____

_____

_____

LIST ANY ALLERGIES YOU HAVE

_____

_____

_____

_____

INSURANCE INFORMATION: **Please complete all information**

PRIMARY INSURANCE	**INSURANCE COMPANY NAME**	**ID OR POLICY #**	**GROUP/CODE**
	INSURANCE COMPANY ADDRESS	**SUBSCRIBER'S SOCIAL SECURITY NO.**	**DATE EFFECTIVE**
	SUBSCRIBER'S NAME	**HOME PHONE**	**RELATIONSHIP TO PATIENT**
	SUBSCRIBER'S ADDRESS	**WORK PHONE**	**SUBSCRIBER'S DATE OF BIRTH**
	SUBSCRIBER'S EMPLOYER	**Employer's ADDRESS**	**ZIP CODE**
SECONDARY INSURANCE	**INSURANCE COMPANY NAME**	**ID OR POLICY #**	**GROUP/CODE**
	INSURANCE COMPANY ADDRESS	**SUBSCRIBER'S SOCIAL SECURITY NO.**	**DATE EFFECTIVE**
	SUBSCRIBER'S NAME	**HOME PHONE**	**RELATIONSHIP TO PATIENT**
	SUBSCRIBER'S ADDRESS	**WORK PHONE**	**SUBSCRIBER'S DATE OF BIRTH**
	SUBSCRIBER'S EMPLOYER	**Employer's ADDRESS**	**ZIP CODE**
TERTIARY INSURANCE	**INSURANCE COMPANY NAME**	**ID OR POLICY #**	**GROUP/CODE**
	INSURANCE COMPANY ADDRESS	**SUBSCRIBER'S SOCIAL SECURITY NO.**	**DATE EFFECTIVE**
	SUBSCRIBER'S NAME	**HOME PHONE**	**RELATIONSHIP TO PATIENT**
	SUBSCRIBER'S ADDRESS	**WORK PHONE**	**SUBSCRIBER'S DATE OF BIRTH**
	SUBSCRIBER'S EMPLOYER	**Employer's ADDRESS**	**ZIP CODE**

SIGNATURE_____**DATE**_____