Frankfort Physical Therapy, LLC.

7777 W. Lincoln Hwy * Frankfort, Illinois 60423 * (815) 806-8777

Private Insurance Patient Information

Patient:_____ **Patient/Parent Employer:**_____

If Patient is a minor, does responsible party have Legal custody? YES_____ NO_____

Is this injury the result of an accident involving another party? YES_____ NO_____

Responsible Party:_____ **EMPL Address:**_____

Address:_____ **City, State, Zip:**_____

City, State, Zip:_____ **Phone:**_____ **Date of Injury:**_____

Phone:_____ **Name of Relative to contact in case of emergency:**

Patient SS#_____ **Name:**_____ **Relationship:**_____

Date of Birth:_____ **Age:**_____ **Phone:**_____

Patient Status: Single____ Married____Divorced____ Other____

Referring Physician:_____

Insurance Information

Employer:_____ **Name of Insured:**_____

Insured Company:_____ **Insured SSN:**_____

Phone:_____ **Patient's Relationship to Insured:** Self/Spouse/Child/Employee

Policy #:_____ **Effective Date:**_____

Release of Information

I GIVE PERMISSION TO FRANKFORT PHYSICAL THERAPY, LLC. TO RELEASE INFORMATION TO MY INSURANCE COMPANY, ATTORNEY, ASSIGNEES AND/OR BENEFICIARIES.

SIGNATURE:_____ **DATE**:_____

Assignment of Benefits

I AUTHORIZE PAYMENT DIRECTLY TO FRANKFORT PHYSICAL THERAPY, LLC. FOR SERVICES RENDERED TO THE PATIENT NAMED ABOVE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR THE CHARGES NOT COVERED BY MY GROUP INSURANCE PLAN.

SIGNATURE:_____ **DATE:**_____

OUR FINANCIAL POLICY

We have found that communication with our patients regarding our financial policy assists us in providing the best service to you. Please take time to read the following. Your signature is required below. Thank You.

1. **Private Insurance**- Our staff is pleased to bill your insurance company as a courtesy to you after your insurance coverage has been verified. You are requested to provide appropriate billing forms and to assign benefits to responsible party/guardian's responsibility to remit any amount not covered by insurance. A weekly payment plan for your portion, determined by your daily service charge, will be established.
2. **HMO'S PPO'S** – We honor the terms of our contract if one id in effect.
3. **PRIVATE PAY**- Full payment is expected when services are rendered to continue treatment.

AGREEMENT TO PAY

I understand that I am responsible and liable for payment of all charges assessed for professional services rendered. I understand the financial policy detailed above. I understand that I am primarily responsible for all charges (including late charges) regardless of my existing medical coverage of payment to Manteno Physical Therapy, LLC. I understand that I am responsible for meeting my insurance deductible and co- insurance and any non- covered services. Should my account become past due, the balance becomes my responsibility and is immediately due and payable and I will be responsible for all collection and legal costs including reasonable attorney's fees.

ON ATTEMPTING TO VERIFY YOUR INSURANCE BENEFITS, THE FOLLOWING INFORMATION WAS OBTAINED:
PHONE VERIFICATION IS NOT A GUARANTEE OF BENEFITS.
Estimated Insurance Benefits:_____**%** of usual and customary charges.
Patient Portion:_____% and any unpaid balance not covered by your insurance company.
Deductible:_____
Other:_____
Verified by:_____
Patient /Responsible party's Signature:_____**DATE:** _____
Witness:_____

CANCELLATION POLICY

In order to best serve all of our patients, the following policies have been established.

1. A 24 hour notice of cancellation will be requested should you be unable to keep a scheduled appointment. If schedule appointments are repeatedly canceled, a cancellation fee will be charged. This will have to be paid prior to the next treatment session.
2. Failure to appear for 3 or more appointments may result in therapy being discontinued, and your doctor will be notified.
3. In order to resume treatment, a new referral or prescription will be required

Respectfully,
Manteno Physical Therapy, LLC.

I have read and understand the above policies.
SIGNATURE:_____ **DATE:**_____