Yellowstone PHYSICAL THERAPY

Office Use:
Date: _____
Input By: ____

Patient Information

Name: _____

Address: _____

City:_____ State: _____ Zip: _____

Sex: M F SSN#_____-____-_____ Date of Birth:____/____/____

Home Phone#: (_____)_____-_____ Work Phone #: (_____)_____-_____Ext_____

Cell Phone #: (_____)_____-_____ E-Mail: _____

Reminder Preference: ☐ Call ☐ Text ☐ Email

Primary Care Provider (MD,DO,NP,PA):_____ Phone: (____)_____

Employer Name: _____

Student: Y N If yes: Full-time or Part-time

Emergency Contact: _____ Relationship: _____ Phone: (____)_____

Responsible Party/Insured (if different than patient)

Name:_____

Address:_____City:_____State_____

SSN #:_____-_____-_____ Sex: M F Date of Birth:_____/_____/_____

Home Phone#(____)_____-_____ Cell Phone #: (___) _____-_____

Work Phone #(____)_____-_____ Ext____ Employer_____

Relationship to Patient:_____Self_____Spouse_____Parent_____Other_____

Worker's Comp or Auto Claims Only

Claim #: _____ Adjuster/Claim Contact: _____

Employer Name: _____ Phone: (____)_____

Employer Address: _____ City: _____ State: ____

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Patient Financial Policies

- It is the patient's responsibility to provide a current insurance card and method of payment prior to the appointment. Claims such as worker's compensation or auto accidents usually require prior authorization. Please have claim information available in order to expedite the authorization process.
- We will make every effort to verify your insurance coverage for physical therapy services, including deductibles, co-pays, prior authorizations, and any limitations or restrictions on number of visits. However, it is ultimately your responsibility to know and understand the terms and conditions of your insurance policy. You will be responsible for all services rendered not covered or rejected by your insurance company.
- If you have current insurance coverage, we will bill your insurance company for services provided. You will be responsible for any co-pay or deductible at the time of service. If you do not have insurance coverage, the balance for services provided is due at the completion of that session. We will promptly reimburse you for any paid charges that exceed the estimated amount for deductibles and co-pays.
- It is the patient's responsibility to provide a current physician's referral or prescription prior to the initial examination if required by their insurance company.
- Some policies, including Medicare, have an annual limit on the amount of physical therapy services that can be billed in a calendar year. It is your responsibility to inform us if you have received physical or speech therapy at another facility in the current calendar year.
- Our charges are considered reasonable and customary by insurance industry standards. Charges may vary depending on services rendered and time spent delivering care. If you have financial constraints that you are concerned with, please communicate your concerns with our staff.
- We will send a monthly statement via mail for all balances due. These statements can also be sent electronically upon request. Balances are due within 30 days of the statement date. If you are unable to pay the balance in full, we can arrange to have a monthly payment automatically deducted from a debit or credit card. We will not accept a payment plan without a valid debit or credit card on file. Our minimum monthly payment is $50 or 10% of the account balance, whichever is greater.

By signing below, you are agreeing to the following statements:

- ***I hereby assign and authorize payment directly to Yellowstone Physical Therapy, herein specified and otherwise payable to me, but not to exceed the facility's regular charges for this period of treatment. I understand I am financially responsible for charges not covered or paid by my insurance policy or worker's compensation claim. I understand that should I default on payment of my account and collection agency services are required, all costs of collections up to 40% of the balance , including attorney/court costs will be added to the balance of my account.***
- ***Yellowstone Physical Therapy is hereby authorized to furnish and release such professional and clinical information as may be necessary for the completion of my medical claims by valid third-party agents or agencies from the medical records compiled during treatment. Yellowstone Physical Therapy is hereby released from all liability that may arise from the release of said information.***
- ***I hereby acknowledge that I have received a copy (upon request) or have read this practice's privacy policy (attached to this packet).***
- ***I hereby agree to treatment at Yellowstone Physical Therapy as prescribed by my physician or per my own self-referral.***

Patient Signature: _____ Date: _____

Responsible Party Signature: _____ Relationship: _____ Date: _____

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Patient Name:

No Show & Appointment Cancellation Policy

****Please Read Carefully****

Please provide our office with 24-hour notice to change or cancel an appointment. Patients who fail to attend a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment are responsible for a $50.00 office visit charge. This charge **cannot** be billed to insurance and must be paid on or before the next scheduled appointment.

We reserve your appointment time just for you. We do not double-book our patients so that we may provide optimum treatment outcomes for all our patients. 24-hour notice allows us to place another patient in your cancelled appointment period to received needed treatment.

We will automatically schedule a reminder phone call, text or e-mail (your choice) to assist you in attending all of your scheduled visits. We have found this to be helpful to most patients. Please let us know if you do want to "opt-out" of these reminders and we will disable this scheduling feature for your visits.

Thank you for providing our office and our patients with this courtesy. **Signing below indicates you understand and agree to the terms of this policy.**

Thank you for giving us the privilege of helping you.

Signature of Patient / Guarantor **Date**

Office Use Only

Reviewed with Patient/Guarantor By: _____