Office Use:
Date: _____
Input By: ____

Yellowstone PHYSICAL THERAPY

Name: _____ Birthdate: ____/____/____ Sex: M F

Billing Address:_____

City:_____ State: _____ Zip: _____

SSN#_____-____-_____ Student: Y N If yes: Full-time or Part-time

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

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

Reminder Preference: ☐ Call ☐ Text ☐ Email

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

Employer: _____

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

How Did You Hear About Us? _____

Responsible Party / Insured Party (if different than patient)

Name:_____ Date of Birth:_____/_____/_____

Address:_____City:_____State_____

SSN #:_____-_____-_____ Sex: M F

Relationship to Patient: ___Spouse___Parent___Other (please specify) _____

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

Work Phone #(____)_____-_____ Ext____ Employer_____

p

Worker's Comp or Auto Claims Only

Worker's Comp/Auto Company: _____ Date of Injury: _____

Claim #: _____ Adjuster/Claim Contact: _____

Employer Name: _____ Phone: (____)_____

Employer Address: _____ City: _____ State: ____

See Reverse Side

No Show & Appointment Cancellation Policy

Please Read Carefully

Your appointment time is reserved especially for you. **YPT requires that you provide our office with a 24-hour notice to change or cancel your appointment. Failure to do so will result in a $50.00 charge**. If you do not show up or call to cancel your appointment you will be charged $50.00 and subsequent scheduled appointments will be canceled.

Your credit card will be stored on file for PT services, payment plans and no-show/late cancellation fees. By signing below, you authorize YPT to charge your credit card for agreed upon services and/or fees as outlined in our no-show/cancellation policy. I understand that my encrypted credit card information will be stored on file for future transactions on my account. This will also apply to payment plans established for PT services.

METHODS OF PAYMENT:

Our office accepts cash, check, credit/debit cards, HSA cards.

Signing below indicates you understand and agree to the terms of this policy.

_____ _____ _____

Printed Name **Signature** **Date**

Patient Financial Policy and Consent for Treatment

1. I consent to examination, treatment and procedures that may be performed during office visits considered necessary by the physical therapist.
2. I authorize the release of any medical information necessary to determine benefits payable for insurance claims for services rendered and agree that all proceeds of insurance are assigned to this office where applicable.
3. I understand that I am financially responsible for all charges whether paid by my insurance or not.
4. I understand that Yellowstone Physical Therapy will do their best to help me understand my insurance benefits, but it is ultimately my responsibility to know my benefits and insurance coverage.
5. I understand that should I default on payment of my account and collection services are required, all costs of collections, up to 45% of the balance, including attorney/court costs, will be added to the balance of my account.
6. I agree to make monthly payments on unpaid balances exceeding sixty (60) days even when insurance claims are pending. These payments will be established in accordance with YPT policy.
7. A one percent (1%) finance charge may be assessed against the unpaid balance of all accounts that I am responsible for in accordance with YPT policy.
8. If YPT bills my insurance company directly, I will pay my copay/coinsurance per visit at the end of each visit.
9. Per HIPPA regulations, I acknowledge that this office has a posted Notice of Privacy Practice available in the patient reception area. A copy is available by request. We will not use or disclose your health information without your authorization, except as described in this notice.

Signing below indicates you understand and agree to the terms of this policy.

_____

Signature of Patient / Guarantor **Date**