



# MEDICAID/MEDICARE

## PATIENT INFORMATION

Patient \_\_\_\_\_

Last Name First Name Middle Initial

Home Address \_\_\_\_\_

Address City State Zip

Home Phone ( ) - Cell Phone ( ) -

May we leave messages at these phone numbers concerning your appointments/account? YES NO

Date of Injury/Surgery \_\_\_/\_\_\_/\_\_\_ Email \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_ Social Sec.# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Male  Female  Marital Status:  Married  Divorced  Single  Widowed  Separated

Is there an Attorney involved in your case? YES NO

\*If yes, Peak Physical Therapy will not hold your account for settlement. You will be required to make timely monthly payments on any unpaid balances.

Employment Status:  Employed  Unemployed  Retired

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer Address \_\_\_\_\_ Phone # ( ) - \_\_\_\_\_

Responsible Party Name: \_\_\_\_\_  self  spouse  parent  other

### Medicaid/Medicare Insurance Information

Insured's Name \_\_\_\_\_ Policy # \_\_\_\_\_

Insured's Date of Birth \_\_\_/\_\_\_/\_\_\_ Insured's SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### Secondary Insurance:

Insured's Name \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Insurance Provider \_\_\_\_\_ Policy # \_\_\_\_\_

Insurance Address \_\_\_\_\_ Phone Number ( ) - \_\_\_\_\_

Referring Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Date Last seen by physician \_\_\_/\_\_\_/\_\_\_

(Medicaid Patients Only) Healthy Connections Physician \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship  spouse  parent  other

Address \_\_\_\_\_ Phone # ( ) - \_\_\_\_\_

### How did you hear about Peak Physical Therapy? (Circle one)

Physician Family/Friend Previous Patient Advertisement Other \_\_\_\_\_

Our office will file insurance claims for all reimbursable services, to both your primary and secondary insurance carriers. You are responsible for all deductible, co-pay, and non-covered services amounts. If at any time your benefits are terminated for any reason you consent that you are responsible for any unpaid balances. If unpaid balances are not paid or in the process of being paid off your account will be turned over to a collection agency within 180 days of your last date of service. I hereby consent to such physical therapy procedures as may be rendered by Peak Physical Therapy. There is also consent for authorization of all insurance benefits to be paid directly to Peak Physical Therapy, and assumption of all financial responsibility for the balance of charges not included in the insurance coverage. Peak Physical Therapy has the authority to release any information necessary to the insurance company for the processing of medical claims and to photograph for medical purposes only. Peak Physical Therapy is released from disclosure of the patient's records as provided by this paragraph.

"I request that payment of authorized Medicare/Medicaid benefits be made either to me or on my behalf to Peak Physical Therapy for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services, formally the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

Signature of Patient/Responsible Party \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_



## NO-SHOW, CANCELLATION POLICY

Our "No-Show, Cancellation Policy" is as follows: All patients who do not cancel their appointment within 24-hours or more of their scheduled appointment will be charged **\$20.00** at their next appointment. This fee can be waived for patients who re-schedule their appointment within that week.

Patients who do not show up to their appointment and do not call to cancel will receive a **\$25.00** "No-Show" fee.

**I HAVE READ AND UNDERSTAND THE "No-Show, Cancellation Policy"**

\_\_\_\_\_  
PATIENT/RESPONSIBLE PARTY SIGNATURE

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
DATE