The Center for Sports and Physical Therapy

4411 S. Adams Street
Marion, IN 46953

1310 Manchester Avenue
Wabash, IN 46992

NEW PATIENT INFORMATION

Patient Name (Last, First, Middle Initial)		Date	Home Phone
Address (Street, Apt., City, State, Zip)			Cell Phone
(Circle) Male or Female	Birth Date	Social Security Number	*(Circle)* Marital Status M S W D
Employer	*(Circle)* Full or Part-time	Contact Person	Work Phone
Referring Doctor			Doctor's Phone
Emergency Contact Person and Relationship			Emergency Contact Phone
Email Address			

RESPONSIBLE PERSON/COMPANY INFORMATION

Responsible Person (Last, First, Middle Initial)			Relationship to Patient
(Circle) Male or Female	Insured's Birth Date		Social Security Number
Address (Street, Apt., City, State, Zip)			Home Phone
Employer	*(Circle)* Full or Part-time	Contact Person	Work Phone
Employer Address (Street, City, State, Zip)			

INSURANCE INFORMATION

Primary Insurance Company	Policy Holder's Name	Date of Birth	Social Security Number
Secondary Insurance Company	Policy Holder's Name	Date of Birth	Social Security Number
Third Insurance Company	Policy Holder's Name	Date of Birth	Social Security Number

REASON FOR REFERRAL

(Circle) Accident/Injury: Work Auto Sport Other or Other Medical Condition
Date of Injury or Onset of Condition:

NEW PATIENT INFORMATION CONTINUED

Previous Medical History (Circle if applicable)

Allergies	Arthritis	Asthma	Cancer
Currently Pregnant	Diabetes	Fainting	Fibromyalgia
Heart Disease/Attack	High Blood Pressure	Impaired Circulation	Impaired Sensation
Kidney Disease	Orthopedic Surgery	Osteoporosis	Pacemaker
Seizures	Stroke/CVA	Tuberculosis	Other_____

If None of the Above Disorders Apply Please Check This Box ☐

As a participant in Federal and State Insurance programs, The Center for Sports and Physical Therapy takes the necessary steps to ensure that qualified disabled persons, including those with impaired sensory or speaking skills, are not denied effective notice because of their disability with regard to consent. If you have vision impairment, we will be happy to read this information to you. Sign language interpretation will be provided to you without charge, should you require or so desire.

1. Information Accuracy: "I verify that the New Patient Information form I completed is accurate and correct."

2. Authorization to Dispense Medical Information: "I authorize the release of any medical information necessary to process my claim by The Center for Sports and Physical Therapy and any member, associate, or designee and understand that all communication and records are considered confidential. "

3. Personal Valuables Policy: "I understand that The Center for Sports and Physical Therapy and any member, associate, or designee is not responsible for personal valuables."

4. Evaluation Consent: "I understand that I have been referred for a physical/occupational/or functional capacity evaluation. I am aware of the inherent risks and hereby acknowledge my consent."

5. Assignment of Insurance Benefits: "I request payment of Insurance benefits directly to The Center for Sports and Physical Therapy on my behalf for Physical and/or Occupational Therapy services rendered to me."

6. Acknowledgment of receipt of Notice of Privacy Practices, "I acknowledge receipt of the Notice of Privacy Practices.

Patient or Guardian Signature _____ **Date**_____

7. Medical Consent "The benefits and risks of treatment have been explained to me and I hereby consent to receive medical treatment at The Center for Sports and Physical Therapy."

Initials or signature denotes consent: _____

FINANCIAL STATEMENT OF THE CENTER GROUP

PLEASE READ CAREFULLY!

Thank you for choosing The Center for Sports & Physical Therapy as your health care provider. We are committed to your treatment being successful. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to treatment.

OFFICE SERVICES: Full payment is due at the time service is rendered. For insured patient's this applies to any deductible, co-insurance, or co-pay amounts. Non-insured patients must make payment arrangements through the Business Office before starting treatment.

NO SHOW /CANCELLATION POLICY: There is a $25 fee for missed appointments & cancellations with less than 24 hour notice given.

MEDICARE: We are a participating office. **Medicare patients are responsible for their deductible and co-pay.**

INSURANCE: Responsibility for payment is your obligation regardless of insurance coverage. If you have coverage, your claim will be filed with your insurance company. For some plans, there will be non-covered services, deductible, or co-payments. We are pleased to assist you in preparation of your insurance claim forms. We want to make sure, however, that you understand that payment for services is your responsibility. Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims. Reduction or rejection of the claims does not relieve your financial obligation. **Co-payments, co-insurance, & deductibles are due at the time service is rendered.**

MINORS: The person who brings a minor in for treatment is responsible for all fees incurred. This includes any co-pay, deductible, or non-covered services. A parent/guardian must remain on the premises with a minor during treatment sessions.

CASES INVOLVING LITIGATION: (auto accidents, slips & falls, etc.). Provided there is liability insurance coverage available, we will file your claims to that insurance. Should your policy/benefits become exhausted it is this offices policy to file those claims to your health insurance. Should you not have health insurance the account will become self pay.

RETURNED CHECKS: A fee of $30.00 will be charged for each check returned to us.

STATEMENTS: Statements are sent once a month for accounts with balances. For accounts with insurance, a statement is sent once your insurance company responds to our claims. The balance of your account is due in full at the time the statement is received. Balances over 30 days will incur a minimum $5 monthly processing fee.

UCR (Usual and Customary Rates): Our practice is committed to providing the best treatment possible for our patients. We charge what is at or below usual and customary for our area. You are responsible for paying the bill in full regardless of your insurance carrier's determination.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. All patients must complete our "Patient Information Form" and "Financial Statement" before seeing the therapist.

Statement of Financial Responsibility/ Assignment of Insurance Benefits/Authorization to Release Information

I hereby authorize direct payment of my insurance benefits to The Center Group, 4411 South Adams Street, Marion, Indiana 46953, for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. If for any reason the account should become delinquent, I agree to pay for any additional costs of collection of this account including, but not limited to: collection agency fees equal to 30% of the balance due, finance charges, legal costs, and attorney fees.

A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I have also read, understand, and accept all of the above mentioned parts of The Center Group's financial policy.

Signature: _____ ***Date:*** _____

Medicare Therapy 2016 and Home Health Care Alert

The Center Group, LLP wants to provide you with the very best care. In order for us to process your Medicare claims, we need the following information.

1) Have you received any physical therapy, occupational therapy or speech therapy since January 1, 2016?

Yes_____ No_____

If yes, what type (circle): Physical Occupational Speech

2) Are you currently receiving any care in your home, including a nurse, physical therapist, occupational therapist, home health aid or social worker?

Yes_____ No_____

If yes, who is providing this service to you?

Name:_____

Phone Number:_____

In the event any type of home health care services are initiated while you are our patient, or you are scheduled to receive therapy at another outpatient facility, you must notify us prior to receiving treatment. Otherwise, you may be held responsible for any resultant nonpayment by Medicare.

Medicare Patient Certification and Payment Request

"I request that the payment of Medicare benefits be made to The Center for Sports and Physical Therapy, on my behalf, for Physical and/or Occupational Therapy services rendered to me. I authorize any holder of medical or other information about me, to release to The Center for Sports and Physical Therapy, and to the Health Care Administration and its agents, any information needed to determine these benefits and process associated claims."

Patient Signature_____ **Date**_____