TEAM IOWA | PHYSICAL THERAPY

Patient Information Form

Patient Name: _____ DOB: _____

Cell Phone: _____ Email: _____

Address: _____Zip_____

How did you hear about us? _____ Text Reminders? Y N

Marital Status: _____ Employer: _____ □ Full time □ Part time

Emergency Contact: _____ Relationship: _____ Phone: _____

Physician Name (first/last): _____

Injury:_____Injury/Surgical Date:_____

Health Insurance Company: _____

Policy Holder: _____ Policy Holder DOB: _____

Policy # _____ Group # _____Phone #_____

Secondary Health Insurance Company (if applicable): _____

Policy Holder (if different): _____ Policy Holder DOB: _____

Policy # _____ Group # _____

Insurance Disclaimer: A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service.

Insurance Liability for Payment: Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized by your health insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service.

Beneficiary Agreement: I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

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PATIENT INFORMATION CONSENT FORM

I have read and fully understand Team Iowa Physical Therapy's Notice of Privacy Practices. I understand that Team Iowa Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluation of the quality of services provided and administrative operations related to treatment or payment. I authorize the release of information left in a voice mail or text message and understand there is some level of privacy risk associated with this form of communication. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify Team Iowa Physical Therapy in writing. I also understand that Team Iowa Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests of restriction. I hereby consent to the use and disclosure of my personal health information for purposes as noted in Team Iowa Physical Therapy Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying Team Iowa Physical Therapy in writing at any time.

ASSIGNMENT OF BENEFITS

I hereby assign all medical benefits to which I am entitled to Team Iowa Physical Therapy in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing, as well as all reasonable costs associated with the collection of this debt. This includes, but is not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. By providing us with your wireless/cell phone number, you are hereby granting us and our agents or independent contractors, your consent to receive calls on your wireless/cell phone number for billing and debt collection purposes. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Team Iowa Physical Therapy as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting actives of negligence.

CONSENT FOR CARE AND TREATMENT

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, hereby consent and authorize Team Iowa Physical Therapy, its agents, associates and employees, to provide care and treatments to me per program policy and/or as prescribed by my physician. A representative of Team Iowa Physical Therapy will explain my plan of care and answer my questions. I understand that the care plan may change and, if so, these changes will be discussed with me. I agree to notify Team Iowa Physical Therapy, my physician or others providing care of any adverse reactions or other significant events relating to my health. I acknowledge that no guarantees have been made to me as to the effect of such examination or treatment of my condition by Team Iowa Physical Therapy, its agents associates and employees. I understand and agree that the terms of this financial policy may be amended by the practice at any time without prior notification to the patient/guarantor. I have read, understand and agree to the terms of this agreement freely and voluntarily and intend by my signature that this be a complete and unconditional release of all liability to the greatest extent allowed by law.

Patient/Guardian Signature: _____Date: _____