Acct. # _____

PATIENT INFORMATION FORM

Patient Name:_____ Date:_____

Home Address:_____CITY_____ZIP_____

D.O.B:_____ Gender:_____

Phone No: (H)_____ (W)_____ (C)_____

Email_____ Is your cell phone text capable? Y N

Patient Drivers Lic. #_____ State:_____

Employer:_____ Occupation:_____

Work Address:_____

Single_____ Married_____ Other:_____ Spouse Name:_____

Spouse's Employer_____ Work No:_____

Employer's Address:_____

Person to contact in Emergency:_____ Relationship:_____

Phone No:_____ Address:_____

Referring Physician: _____

Responsible Party(for minors only)

Name:_____ Relationship:_____

Address:_____ Phone No:_____

Driver's License #:_____ D.O.B:_____

Employer:_____ Work No:_____

As a patient (or legal guardian of a minor), I agree to pay for all services rendered in accordance with the terms and conditions set forth in the billing policy of Mullen Physical Therapy, INC. In the event legal action should become necessary to enforce payment of any charges, I agree to be responsible for all reasonable attorney's fee.
ASSIGNMENT: I hereby authorize my insurance benefits to be paid directly to Mullen Physical Therapy, INC. I am financially responsible for non-covered services.

_____ **Date**_____
Patient or Guardian Signature

Medical Information

What date did this condition or injury occurs? _____

Was this condition or injury the result of an accident? _____
If yes, was it the result of an auto accident?_____
Is this injury under litigation?_____
If yes, write your attorney's name and phone number:_____

Was this condition or injury job related?_____
Have you filed for worker's compensation?_____
If yes, complete the following:

Third Party Payor:_____ Phone No.:_____

Address:_____

Name of Adjuster:_____ Claim #_____

Insurance Information

Name of Insured:_____ Relationship:_____

D.O.B:_____

Insurance Company:_____

Insurance Company Phone Number: _____

Insurance Company Address:_____

I.D No.:_____ Group No.:_____

Do you have additional insurance? Yes No
(We do not bill secondary insurance company)

Name of Insured:_____ Relationship:_____

Insurance Company:_____

Insurance Company Address:_____

I.D No.:_____ Group No.:_____

Billing Policy

There is a $150.00 deposit due at the time of the first visit. This will be credited to your account.

As a courtesy, this office will bill primary insurance semi-monthly for current charges, but cannot assume responsibility for guaranteeing that insurance will pay.

If your insurance company does not pay within 60 days, you will be responsible for the balance on your account.

This office does not bill secondary insurance, although upon request, we can provide claim forms for your use.

Even though an insurance claim is filed, you will receive a statement each month requesting payment if your account has a balance due. For most patients, this will reflect your co-payment responsibility. Payment is due within 10 days.

Please be aware of the amount of your yearly deductible. Also be advised that there are sometimes limitations placed on the dollar amount and/or number of visits for outpatient physical therapy. Please check your insurance policy carefully.

This office does not accept liens. If your case is under litigation or you suspect it may be in the future, please see the office manager.

This office cannot accept the final responsibility for collecting from insurance or negotiating a settlement on a legal case. If your insurance has not made payment on this account, please check with them.

There is a charge for appointments not canceled at least 24 hours in advanced. If 24 hours advance notice is not provided, the patient is responsible for 50% of the expected bill.

The patient is ultimately responsible for all charges.

I HAVE READ THE ABOVE TERMS. I UNDERSTAND AND ACCEPT THEM.

_____ **Date:**_____

Signature