PATIENT INFORMATION FORM

Please print clearly.

First Name: ______________________________ Last Name: ______________________________

DOB: __________ Sex: ☐ M ☐ F Drivers Lic #: ______________ SS #: _______-______-______

Street Address: ____________________________ City ______________ State ____ Zip ______

Home # (________) ________________________ Cell # (________) ________________________

Mark if Applicable: ☐ Health Insurance ☐ Medicare ☐ Workers Comp ☐ Lien ☐ Cash

Employer: ______________________________________ Phone (_______) __________________

Employer's Address: ____

Occupation: ____________________________ Email: ________________________________

Referring Physician: ______________________________ Phone (______) __________________

Attorney/ Adjuster: _______________________________ Phone (______) __________________

Date of Injury: ___________________________________ Claim #: _________________________

EMERGENCY CONTACT: NOT LIVING WITH YOU

Name: ____ Phone (______) __________________

Address: ____

Relationship: ____

PATIENT AUTHORIZATION

Please read carefully.

CONSENT

I authorize Brighton Therapy to provide my treatment as prescribed by my physician.

PAYMENT OF BENEFITS TO BRIGHTON THERAPY

I understand I am financially responsible for all non-covered services and all insurance deductibles. I authorize Brighton Therapy to release any information my insurance may request.

Signature: ____ Date: ______________________

A photocopy of this authorization will be considered as valid as the original.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY

I, ______________________________, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: ____ Date: ______________________

PATIENT INFORMATION CONSENT FORM

I have read and fully understand Brighton Therapy's Notice of Information Practices. I understand that Brighton Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. 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 the practice. I also understand that Brighton Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Brighton Therapy's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Signature: ____ Date: _________________________

PAYMENT POLICY

Please read carefully and sign at the bottom of the page indicating your understanding and acceptance of our policies and procedures. We are committed to providing you with the best possible care.

PAYMENT IS DUE AT TIME OF SERVICE.

If you have medical insurance, we can as a courtesy submit your claim for you.
We will have you pay for any **deductibles and co-pays** required at the time of service.

CANCELLATION POLICY

I understand I will be charged $75.00 for a no-show or cancellation of less than 24 hours notice. Repeated **late cancellations or no-shows** are disruptive to the optimal delivery of care and may indicate a lack of commitment to your health and wellness. **Excessive late cancellations will result in discontinuing of your Physical Therapy**. In the event that you are discharged from our care, your referring provider will be notified.

Initial Here: ________

PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS PAYMENT ARRANGEMENTS HAVE BEEN MADE AND APPROVED IN ADVANCE.

YOU MUST REALIZE THAT:
Not all services are covered by all insurance policies. Some companies select certain services that they will not cover.

The "Usual and Customary Charges" that may be quoted by your insurance company are charges that have been determined and set by your insurance company. They do not necessarily reflect our fees.

We must emphasize that as health care providers, **our relationship is with you**, not your insurance company. While filing your insurance claims for our patients is a courtesy that was extended, **ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICE IS RENDERED**.

We do realize that there are times that a temporary financial problem may affect your payment of our account. In that case, PLEASE contact us for assistance so that we may be able to set up payment options for you.

If you have any questions, feel free to ask us. We will be glad to help.

REGARDLESS OF ANY INSURANCE COVERAGE THAT I MAY HAVE, I AGREE THAT IT IS MY RESPONSISBILITY TO PAY MY BALANCE AND WILL PAY ANY BALANCE DUE.

Signature: ____ Date: _________________________