Finley Physical Therapy and Sports Medicine, P.A.

Patient Information

Name____ S.S.#__________________________________

Mailing Address____ City/St./Zip________________________

Home Phone No.____________ Cell Phone No. _______________ Marital Status _____ Sex ____ DOB ________

Patient's Employer______________________________________ Work Phone No.________________________

Emergency Contact____ Phone No.__________________________

Date of injury or surgery ________________ Is your condition related to work_______

Doctor who referred you here____

Guarantor/Insured Party (Please complete if different than patient)

Name____ S.S. #____________________________

Mailing Address____ City/St./Zip_____________________

Home Phone No.________________________ Birth Date______________ Sex_______

Insured Employer____________________________________ Work Phone No.__________________________

Relationship to Patient____

PLEASE READ AND INITIAL EACH LINE

STATEMENT OF FINANCIAL RESPONSIBILITY

1.______ I understand payment is due at the time of service unless arrangements have been made in advance. Checks and cash accepted as forms of payment.

2.______ I authorize Finley PT to file my insurance(s) as a courtesy to me and release any medical data needed to process the insurance claim. I understand payment for these services will be mailed directly to this office.

3.______ I recognize that ultimate financial responsibility for my account remains mine. If my insurance company does not pay the practice within a reasonable period, I will be responsible for the payment.

4.______ I understand that not all insurance plans cover all services. In the event my insurance plan determines a service to be "not covered" I will be responsible for the complete charge. I hereby guarantee payment in full of any and all charges for services rendered not covered by any health insurance plan, including all deductible and coinsurance amounts.

5.______ I understand that if I fail to provide accurate insurance coverage information, Finley PT will not be able to file my claim within the prescribed time limits and I, therefore, forfeit any and all rights to insurance benefits that would have been available to me. This includes any benefits that would have provided discounts, deductibles and other amounts that would have otherwise not been my responsibility as a patient.

I have read and understand the statement of financial responsibility and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

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Patient Signature (or responsible party if minor) Date