PT SOLUTIONS, INC. Outpatient Therapy Treatment Agreement

This is an agreement in which the patient consents to Physical Therapy Treatment upon the following provisions. The patient and/or responsible party, and the facility agree to the following:

SECTION A:
SKIP THIS SECTION UNLESS YOUR INJURY IS RELATED TO:
1) A work injury 2) A motor vehicle accident

Insurance Company:_____ Claim Number:_____
Insurance Address:_____
Insurance Phone:_____ Claim Adjuster:_____
Employer at time of injury:_____ Date of Injury:_____
Is your claim Open?_____ In what state did the accident occur? _____*
Is this a re-injury of a previous claim?_____ If so, what is the date of the original injury?_____
Is your Claim in litigation?_____ If so, provide the name of your attorney and any other pertinent information_____

**We are not subject to out-of-state Workers' Compensation programs, rules, and regulations. We will provide you with billing information to submit to your out-of-state Workers' Compensation program if you wish. As the patient, you are responsible for payment in full of services provided by this facility.*

Please present your insurance and identification cards to the front office staff.

SECTION B: TO BE COMPLETED BY ALL PATIENTS:

Patient Name:_____ Birth Date:_____

Physical Address:_____

Mailing Address:_____
City:_____
State:_____ Zip Code:_____ Employer:_____
Home Phone:_____ Work:_____ Cell:_____

Social Security # _____ Driver's License Number: _____

E-Mail:_____

Marital Status: S M W D DP Other: Sex: M F

Emergency Contact: _____Relationship: _____
Home Phone: _____ Work: _____ Cell: _____

Primary Physician: _____ Phone: _____

Patient Initial: _____ **Please continue to reverse side:**

Please read each section carefully and initial in the space provided:

_____ FINANCIAL RESPONSIBILITY: I guarantee payment of therapy services provided to me by PT Solutions, Inc. (facility). I understand that the facility does not accept responsibility for negotiating a settlement of a disputed claim, and that I am responsible for payment of my account. As a courtesy, the facility will bill my insurance(s). I understand that I may be responsible for a co-payment and/or co-insurance as services are rendered. Any balance remaining after initial insurance payment has been received will be forwarded to me by the facility and is payable upon receipt. Interest of 1.5% (18% per annum) may be added to all accounts 30 days past due. In the event of an account being placed with an attorney or collection agency, the undersigned agrees to pay reasonable attorney fees, legal expenses, and/or lawful collection costs in addition to all other sums due to the facility.

_____ TREATMENT CONSENT: I consent to the examinations and treatments ordered or recommended by my physician, referral source, and/or my physical therapist.

_____ RETURNED CHECK FEE: I acknowledge that there is a fee of $25.00 if a check I provide is returned due to insufficient funds.

_____ AUTHORIZATION FOR RELEASE OF INFORMATION: PT Solutions, Inc. is authorized to furnish and release, according to facility policy, such professional and clinical information as may be necessary for treatment and the completion of my medical claims by valid third party agencies from the medical records compiled during my treatment. The facility is released from all legal liability that may arise from the release of said information.

_____ ASSIGNMENTS AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I assign and authorize payment for services directly to PT Solutions, Inc., otherwise payable to me; not to exceed the facility's regular charges for the period of treatment. **I understand that I am responsible to PT Solutions, Inc. for charges not covered or paid by my insurance(s).**

_____ASSIGNMENTS AND AUTHORIZATION TO BILL MEDICARE, IF APPLICABLE: I assign and authorize payment for services directly to PT Solutions, Inc., otherwise payable to me; not to exceed the facility's regular charges for the period of treatment. **I understand that I am financially responsible for 20% of the Medicare Part B Services provided by the facility, though, if applicable, the facility will bill my secondary insurance for said amount upon request.**

NOTICE OF PRIVACY PRACTICES: I acknowledge that I was offered a copy of the Notice of Privacy Practices.
_____Took Copy of Policy _____Declined Copy of Policy

The Patient and/or Responsible Party agree and may receive a copy of this signed Outpatient Therapy Agreement upon request.

Patient or Responsible Party:

_____

Relationship_____
Date:_____

Facility Witness:

_____

Date: _____