VITAL PHYSICAL THERAPY
INTEGRATIVE HANDS-ON THERAPY

A member of PT-MDKinect

Patient Information

Full Name:	DOB:	SSN:
Address:	City/State:	Zip:
Phone: (home)	(cell)	(work)
Email Address:	Sex: M/F	
Who can we thank for referring you?	How did you hear about our practice?	
Referring physician:	Office Phone:	Office fax:
Address:	City/State/Zip	Date of next visit
Primary Care Doctor:	Office Phone:	
Address:	City/State/Zip:	Date of next visit

Primary Insurance

Primary Insurance Plan:	Policy Holder Name:	
Primary Insurance ID Number:	Relationship to Policy Holder:	
Primary Insurance Group Number:	Medicare Replacement Plan?	
Address:	City/State:	Zip:
Phone:		

Secondary Insurance

Secondary Insurance Plan:	Policy Holder Name:	
Secondary Insurance ID Number:	Relationship to Policy Holder:	
Secondary Insurance Group Number:	Phone:	
Address:	City/State:	Zip:

Condition Information

Is your condition due to an accident?	Date of Accident:	
Type of Accident: Auto/Work/Home	If other, please qualify:	
Did you file a claim? Y/N	Adjuster's Name: Claim #:	Adjuster's Contact Number:
Do you have an attorney?	Attorney's Name:	Attorney's Contact Number:

Insurance verification

Thank you for choosing Vital Physical Therapy, LLC. We are contracted with certain insurance companies. We will verify your benefits as a courtesy to you. The verification we receive from your insurance plan is not a guarantee of benefits. We recommend that you also verify your therapy benefits with your insurance company prior to your first appointment and let us know if there are inconsistencies with the coverage quoted.

Assignment of Medical Insurance Benefits

We will work with you and with your insurance carrier to submit claims, but would like you to understand our office policy regarding insurance assignment. Payment is expected at the time of service unless we accept assignment from your insurance carrier or previous payment arrangements have been made. For our office to accept insurance assignment, we ask that you read and sign the following.

You acknowledge that it is your responsibility to:

1. Provide complete, current information on medical insurance coverage for yourself (or the patient if under 18). Including presenting a valid insurance card at the time of service.
2. Pay applicable co-payment at the time of service. A minimum per-visit charge may be asked for high deductibles that have not yet been met.
3. Present a valid referral or authorization number for all services (if required by your insurance company). Your primary care physician or referring specialist can help you if needed.
4. Inform us if the patient's need for medical services is due to a motor vehicle, worker's compensation or other accident.
5. Make payment within 30 days on any balance on your account for amounts due such as deductibles, coinsurance, co-payments or non-covered services.
6. Verify that this provider is in network with your particular insurance plan under your insurance carrier.

You are ultimately responsible to pay the medical bill if your insurance company does not honor the assignment of benefits in whole or in part.

Your signature below indicates:
1. You understand and accept our policy of assignment of insurance benefits.
2. You attest to the accuracy and completeness of the medical insurance coverage information.
3. You authorize this office to release medical information necessary to process your claims and appeals.
4. You authorize payment of medical benefits to Vital Physical Therapy, LLC.

Patient or Responsible Party Signature:	Date Signed:
(Responsible Party, Relationship to patient):	