

# PATIENT DATA SHEET

Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Patient Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: Home ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ ext: \_\_\_\_\_  
Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F Marital Status: M S D W U

## RESPONSIBLE PARTY INFORMATION

Relation to patient: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Parent \_\_\_\_\_ Other \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: Home ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ ext: \_\_\_\_\_  
Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M / F  
Employer: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

## ACCIDENT INFORMATION

Reconstructive Surgery? Y / N Accident Type: None W/C Auto Other  
Accident/Injury/Onset Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Accident Details: \_\_\_\_\_

## INSURANCE INFORMATION

Primary Insurance Name: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_  
Policy/Claim # \_\_\_\_\_ Group # \_\_\_\_\_  
Insured Name: \_\_\_\_\_ Auth #/ Pre-Cert # \_\_\_\_\_  
Secondary Insurance Name: \_\_\_\_\_ Phone ( ) \_\_\_\_\_  
Policy/Claim # \_\_\_\_\_ Group# \_\_\_\_\_  
Insured Name: \_\_\_\_\_ Auth#/Pre Cert # \_\_\_\_\_

## OFFICE USE ONLY

Referring Physician: \_\_\_\_\_ UPIN# \_\_\_\_\_  
Appointment Date: \_\_\_\_\_ Therapist:: \_\_\_\_\_  
Rx Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Part of Body: \_\_\_\_\_

# AGILITY PHYSICAL THERAPY & SPORTS MEDICINE

## CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give consent for AGILITY to furnish medical care and treatment To \_\_\_\_\_ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Gaurdian \_\_\_\_\_ Date \_\_\_\_\_

## BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Private insurance and third party payors to AGILITY. A photocopy of this assignment is to be considered as valid as the original. I, hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_

## FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal **usual and customary fee schedule**, you will be responsible for the difference remaining.

If payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to AGILITY.

The above does not apply for those patients that are considered Workers Compensation. However, be advised if you claim W/C benefits and are subsequently denied benefits, you may be held responsible for the total amount of charges for services rendered to you,

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

The above information has been read and explained to me. **I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.**

\_\_\_\_\_ Date \_\_\_\_\_  
Patient/Guardian/Responsible Party

\_\_\_\_\_ Date \_\_\_\_\_  
Center Representative/Witness

# AGILITY Physical Therapy

## **To Our Patients Regarding Cancellations and No-Shows**

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic, because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/ or your therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

- We require 24 hours notice in the event of cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible. (In cases, this may not work since some forms of treatment do not work well if given two sequential days.)
- There is a \$25 charge for a cancellation without proper notice. This charge will not be covered by insurance, but will have to be paid by you personally.
- For Worker's compensation and Personal Injury patient's documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.
- Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. Either condition can seem to be a reason not to come in: a) you've feeling worse and think the treatment is not working or, b) you're feeling better and it's a great day for wind-surfing. Neither of these conditions is legitimate as a reason not to come: a) if you're in pain, come in and get it fixed, b) if you're out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem, educate you so you won't re-injure yourself, etc.

When you don't show as scheduled, three people are hurt: You because you don't get the treatment you need as prescribed by the doctor and/or PT; the therapist who now has a space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice.

Please co-operate with us in this regard. We're looking forward to working with you.

---

Patient Signature

---

Date

---

Interviewer Signature

---

Date