

MR #: _____

Please Print

YOUR CONTACT INFORMATION

Name: _____ DOB: ____/____/____ SSN: _____

Mailing Address: _____ Gender: M F

Physical Address: _____ E-mail: _____

Do we have your permission to send you our E-News Newsletter? Y N

Phone Numbers: Home: _____ Cell: _____ Work: _____

How can we contact you? (circle all that apply): E-mail Home # Cell # Work #

EMERGENCY CONTACT: _____ Telephone: _____

Your Employer: _____ Address: _____

If Under 18 Years of Age: Responsible Party Name: _____ Relationship to you: _____

Address (if different from patient): _____ Telephone: _____

Please Circle the 'BEST' reason on why you chose GRAY PT as your physical therapy provider

- | | |
|--|---|
| Friend / Relative Recommendation | Saw our advertising (circle one): newspaper; sign; phonebook; community sponsored event |
| Convenience (circle one): Location; hours of operation | Website |
| You have been treated here before | Doctor's Recommendation |
| | Other: _____ |

Doctor Sending you to PT: _____ Family Doctor (PCP) _____

Your Diagnosis— What are we seeing you for? _____ Onset Date: _____

BILLING / INSURANCE INFORMATION — Whom do we bill? Please Check Appropriate Category

Health Insurance _____ Worker's Compensation _____

Auto Insurance _____ Me _____

Primary Insurer: (Name) _____

ID/ Certificate/ Policy Number _____

Subscriber's Name: _____ Your Relationship to the Subscriber: _____

Secondary Insurer: (Name) _____

ID/ Certificate/ Policy Number _____

If either of the Insurer's listed above is **Worker's Comp or Motor Vehicle Accident** related, please provide us with the **Claim Handler's Name, Telephone Number and your File / Claim Number.**

If you are represented by an attorney for litigation, please provide the attorney name, address and phone number below

CONTINUED ON BACK



CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent and authorization for Gray Physical Therapy Center, PA, to provide examination, treatments, and services by a physical therapist to myself/designee:

I realize and certify that no guarantee or assurance has been made as to the results that may be obtained for such examinations, treatments, and services.

ASSIGNMENT AND RELEASE

I hereby authorize my insurance company to pay benefits directly to Gray Physical Therapy Center, PA, or its designee, for services rendered and agree that I am financially responsible for non-covered services. I also authorize Gray Physical Therapy Center, PA, to release any and all requested information pertaining to treatment necessary to process a claim(s) for physical therapy benefits. (Physician, Insurance company, Attorney etc)

FINANCIAL POLICY STATEMENT

It is our policy to bill your insurance carrier as a courtesy to you, although you are responsible for the entire bill when services are rendered. Questions and/or concerns about the bill and payment policies should be directed to our Billing Department, at 866-533-8175

Evidenced by my signature below, I agree to pay any balance of the provider service charges over and above the insurance coverage. I understand that account balances remaining due 90 days and more after the date services were provided will be subject to a 1.5% finance charge per month and any cost incurred in the recovery of those charges including collection costs and reasonable attorney's fees will be my responsibility. Customized payment programs may be available on a pre-arranged basis.

I understand and authorize Gray Physical Therapy Center, PA, to bill my health insurance if a claim is contested, or remains unpaid after 30 days from submission, by my Worker's Compensation or Liability Coverage. Further, if my claim is covered under liability coverage (due to accidental injury and/or motor vehicle accident), I authorize my attorney and/or the responsible party to make payment in full directly to Gray Physical Therapy on my behalf. I understand that if I settle a case with Workers' Compensation or a Third Party Liability Insurer, it is my sole responsibility to ensure that my claims have been paid in full by the insurer, or that I will be responsible for paying the entire balance personally.

I understand that it is my sole responsibility to understand my insurance coverage, and that I will independently verify my physical therapy benefits with my insurer. Any balance that remains unpaid after my insurer has processed my claims, minus any contractual discount that Gray Physical Therapy is required to extend to me, is my full responsibility.

I have read the above information and understand that ultimately it is my sole responsibility for the payment of my account.

**PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
AND PATIENT RIGHTS AND RESPONSIBILITIES**

I, _____, have been provided access to, and have been offered a copy of, the notice of privacy practices followed by Gray Physical Therapy Center, PA. I was also provided with a copy of the summary of the Privacy Practices and Patient Rights and Responsibilities followed by Gray Physical Therapy Center, PA. I have read and understand the Consent for Care and Treatment; Assignment and Release and Financial Policy Statement as set forth above. I have had an opportunity to read all these documents and ask questions. I consent and agree to all the terms and conditions as set forth in these documents.

Signature of Patient: _____
If patient is a minor, Signed for Patient by: _____ (Relationship): _____

Today's Date: _____ Witness: _____