PATIENT INFORMATION

Patient Name:	**Preferred Nickname**:	**Date of Birth**:
Street Address:	**City/State**:	**Zip Code**:
Home Phone:	**Cell Phone**:	**Email Address** *(for appt reminders only)*:
Employer:	**Work #**:	**Can you be contacted at work regarding appointments? Y N**

PRIMARY HEALTH INSURANCE

Policy Holder:	**Date of Birth**:	**SSN**:
Insurance Provider:	**Employer**:	
If covered by Group Health, have you had Physical Therapy THIS YEAR? Y N	**# of visits**?	
If covered by Forward Health, have you been seen for 20 visits this year? Y N		

SECONDARY HEALTH INSURANCE

(fill in areas that are different than the PRIMARY information)

Policy Holder:	**Date of Birth**:	**SSN**:
Insurance Provider:		

WORKER COMPENSATION CLAIMS

WC Insurance Co:		**Date of Injury**:
Address:	**Phone**:	**Fax**:
Contact Person/Adjuster:	**Claim #**:	

EMERGENCY CONTACT INFORMATION

First Contact:	**Phone #'s**:	**Relationship**:
Second Contact:	**Phone #'s**:	**Relationship**:

Please read and sign the back page of this form upon review

CANCELLATION POLICY

As a courtesy to our staff and other patients, we ask that you provide a **24-HOUR** notice if you are unable to keep your scheduled appointment. After **3 cancellation/no-show** occurrences, we reserve the right to review each case and determine discharge as appropriate.

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers directly to Cornerstone Physical Therapy
- Conduct normal healthcare operations such as quality assessments and physician certifications
- I understand if payment by my insurance company is disputed or delayed, I am responsible for the payment of services rendered

I have been informed by you of your NOTICE of PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such notice of practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Act.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this content in writing at any time, except to the extent that you have taken action relying on this content.

I authorize CORNERSTONE PHYSICAL THERAPY to bill my insurance carrier and receive payment directly from the insurance carrier(s).

I also provide consent for Cornerstone Physical Therapy to provide direct treatment to me as advised by my treating clinician.

PAYMENT POLICY

DEDUCTIBLE: A minimum payment of $50.00 is required **per visit** if your deductible has not been met for the calendar year	**CO-INSURANCE**: Co-insurance refers to the percentage you, the policy holder is required to pay toward this medical bill. Weekly payments may be made toward co-insurance obligations.	**CO-PAY**: The dollar amount you, the patient, is required to pay **in full** each visit based on your health insurance plan. **We request that co-pays be paid at each visit to prevent your bill from accruing to a level that may become difficult to manage.**

IT IS CORNERSTONE PHYSICAL THERAPY'S OBLIGATION TO COLLECT FEES FOR DEDUCTIBLES AND CO-PAYS PER INSURANCE CONTRACT AT THE TIME OF SERVICE.

I have read and understand my insurance policy. I understand **it is my obligation to know what my insurance does and does not cover**. It is also **my responsibility to know if my insurance has deductible, co-insurance or co-pay requirements**.

Patient Signature: _____ **Date**: _____