Patient Information Form

Name: _____Hm Phone: _____

Wk Phone:_____Cell Phone:_____ Please circle Primary No.

I give Skyline Physical Therapy permission to leave a message on my answering machine _____

Employer:_____email address: _____

May we notify you by Email_____ Text Message_____ regarding appointment information

Home Address: _____

City: _____State:_____ Zip Code: _____

Spouse's Name: _____ Wk Phone: _____

Nearest Relative not living with you: _____ Phone: _____

Nearest friend not living with you: _____ Phone: _____

Physician: _____ Phone: _____

Landlord: _____ Phone: _____

Whom may we contact in the case of an emergency?

_____ Phone: _____

Where did you hear about us? (ex. doctor, website, friend, etc.)

_____ Phone: _____

Social Security #: _____ Date of Birth: _____

Who is responsible for this bill? _____

I will be paying today by: cash _____check: _____ credit card:_____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status of the above information.

_____ _____

Signature *Date*

_____ _____

Parent (if minor) *Date*

WELCOME TO SKYLINE PHYSICAL THERAPY SERVICES

We are committed to providing you with the best possible care. If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

If you have insurance, we will be happy to file your insurance claims, however, it is your responsibility to make sure the claims are being paid in a timely manner. While we are able to verify insurance coverage, most insurance carriers will not guarantee payment until they receive the claim and diagnosis. Your coverage may be subject to limitations and we encourage you to check with your insurance company regarding your particular plan.

MEDICARE GUIDELINES

If you have received home health or outpatient physical therapy through another clinic, please advise us.

A written referral signed and dated by your physician is required. There must be evidence in the clinical record maintained by the therapist that a physician has seen the patient at least every 90 days. Therefore, it is the patient's responsibility to make an appointment with his/her referring physician every 90 days from the date of the initial evaluation, if physician has not agreed to therapists plan of care in order for Medicare to reimburse for the services rendered.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

***Payment is due at the time services are rendered unless payment arrangements have been approved in advance by our staff**. This includes charges not covered by insurance, co-pays, and durable medical equipment. Deductibles and coinsurance will be billed. They are due at the time of receipt and will be mailed on the 1st and the 15th of every month. If you are unable to pay the full amount, a payment plan may be arranged for you. We accept cash, check, or credit card.*

A fee of twenty-five (25) dollars will be charged if a client does not arrive for a scheduled appointment without at least 24 hours notification or cancellation. This charge will not be submitted to the client's insurance and will be the sole responsibility of the client.

***Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1.33% per month**. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.*

*If you have any questions, **PLEASE** do not hesitate to ask us. We are here to help you and appreciate that you have chosen our clinic for your care.*

Thank you,
Skyline Physical Therapy Services

_____ _____

Signature *Date*

_____ _____

Parent (if minor) *Date*