

PRIMARY THERAPY SOURCE

Patient Information

Last _____ First _____ MI _____ Employer _____
 SS# _____ BirthDate ____/____/____ M F Work/Cell Phone _____
 Address _____ Home Phone _____
 City _____ State _____ Zip _____ Marital: single married other
 Emergency Contact _____ Relationship _____ Phone _____
 Who referred you? _____ Your primary care physician is _____
 Other physicians seen for this problem _____
 Other therapists seen for this problem _____

Who is the person responsible for charges not paid by insurance? (Disregard if same as patient info)

Last _____ First _____ MI _____ Employer _____
 SS# _____ BirthDate ____/____/____ Work/Cell Phone _____
 Address _____ Home Phone _____
 City _____ State _____ Zip _____ Relation to Patient _____

Insurance	Primary	Secondary
Insurance Company		
Subscriber's Name		
Subscriber's Employer		
Subscriber ID# or SS#		
Group # or Claim #		
Subscriber Birthdate & Gender		
Patient's Relation to Subscriber		

Is your injury sports-related? Yes No Date of Injury ____/____/____
 Is your injury job-related? Yes No Date of Injury ____/____/____
 Is your injury due to a motor vehicle accident? Yes No Date of Injury ____/____/____
 Claims Manager _____ Phone# _____

AGREEMENT/CONTRACT: I fully acknowledge responsibility for the accuracy of the above information. I further understand that my insurance coverage is a relationship between my insurance company and myself. It is my responsibility to be aware of my individual insurance requirements and benefits. I agree to accept full responsibility for payment of my account. I authorize direct payment from my insurance carrier for charges incurred. I authorize release of all information requested by my insurance company as needed for payment on services rendered.

Signature of Responsible Party _____ **Date** _____

PRIMARY THERAPY SOURCE
APPOINTMENT POLICY

It is important that you keep the appointment schedule set by your therapists at Primary Therapy Source. The best way to achieve your health goals is to follow your therapist's instructions and come to therapy at your appointed time.

Three people are affected when a patient calls at the last minute to cancel an appointment or – worse yet – fails to show without the courtesy of notifying our office:

- ◆ You are hurt because we may not be able to fit in your prescribed number of visits during the week. This is particularly true if you are on a work injury claim. Our office is required to report all cancellations and no-shows to your case manager, which can result in termination of benefits.
- ◆ Another patient is affected because that person was unable to schedule in the time slot you reserved.
- ◆ The clinic is hurt because we held a spot specifically for you and often cannot fill that open spot at the last minute.

To insure that all patients have access to Primary Therapy Source, we've implemented the following policies:

Please do not make an appointment that you are not confident you can keep. If you must reschedule, notify our office as promptly as possible.

A notice of 8 business hours is given for any cancellations.

Cancellations made in less than 8 business hours are assessed a \$10 fee for each occurrence.

No-shows are assessed a \$20 fee for each occurrence and your other appointments are removed from the schedule.

No treatment was provided to you due to a last-minute cancellation or no-show. Therefore, we cannot bill your insurance company for cancellations or no-show fees; that is considered insurance fraud.

Assessed fees are to be paid by you prior to your receiving any further treatments.

After 2 cancellations or 1 no-show, you may be asked to see your physician prior to rescheduling.

I understand and agree to abide by the above policy.

Signature _____ Date _____

I authorize Primary Therapy Source to leave appointment reminders on my voice mail # _____ or home answering machine # _____ and/or with the individual(s) named below at my home number. Initial here: _____

Authorized Contact(s) _____

I do not want reminder calls. Initial here: _____