Adams & Giddings
Physical Therapy, PC
Sport & Spine Specialists

Patient Intake Form

Office Use Only:

Date of Intake: _____	**Date Scheduled:** _____
Reminder Call for IE: _____ **Insurance:** _____	**Attire___ Paperwork___ Payment___ Late/CXL Policy___ Early___**

Name: _____ **DOB:** _____ / _____ / _____
as it appears on insurance card with middle initial

Street Address: _____

Billing Address: (if different): _____

City: _____ **State:** _____ **Zip Code:** _____

Phone #1: _____ ☐ Home ☐ Cell ☐ Work **Phone #2:** _____ ☐ Home ☐ Cell ☐ Work **Email:** _____

Social Security #: _____ - _____ - _____

Emergency Contact: _____ **Phone Number:** _____ **Relationship to Patient:** _____

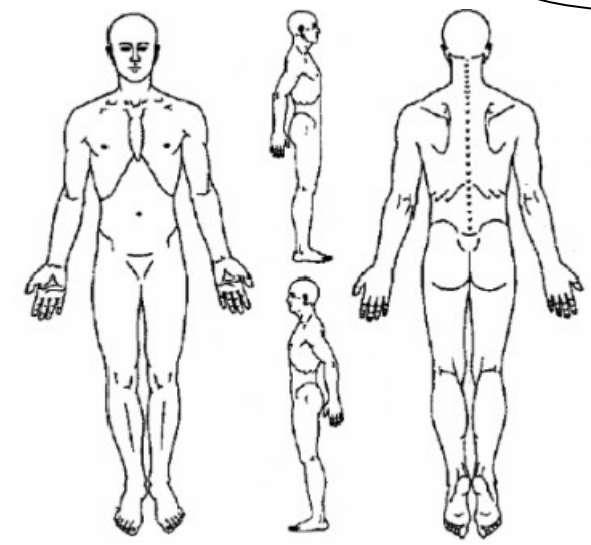
How did you hear about or find our office? _____

For what are you seeking treatment? _____ **Date of injury/surgery:** _____

Is condition related to: ☐ Work ☐ Auto Accident (State: _____) ☐ Personal Liability ☐ None

Have you received any physical therapy in this calendar year? _____

How much pain do you have with this condition? Circle the area of pain and indicate level of pain below:



Pain Scale is 0 - 10:
0 = none / 10 = severe
intermittent / constant

Pain is: _____

Work Status: ☐ Employed ☐ Retired ☐ Disabled *(___ Total or ___ Temporary)* ☐ Student (___ P/T or ___ F/T)

Occupation: _____ **Employer & Phone Number:** _____

Name of Referring Physician & Phone Number: _____

Name of Primary Care Physician & Phone Number: _____

Would you like your records sent to the above physicians? ☐ Referring ☐ PCP ☐ Both ☐ Neither

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PAYMENT OPTIONS: *(Please **INITIAL** next to the payment option you're using)*

_____ Private Pay – *Not using insurance*; I am paying by cash, check or credit card at the time of service.

initials

You have been offered the opportunity to personally pay for your physical therapy evaluation and treatment at Adams & Giddings Physical Therapy, PC. The private pay policy is used in the following circumstances:

1. Patient has no insurance
2. Physical therapy is not covered by patient's insurance
3. Patient chooses to forego insurance benefits

The following conditions apply:

1. Once you have chosen the private pay terms, we will not bill your insurance carrier for services rendered.
2. **Payment is due at the time of service.** We accept cash, VISA, MC or check. **There is a $25.00 service charge for returned checks.**
3. If payment is not paid at the time of service, you will be billed a $15.00 administrative fee in addition to the treatment charge.
4. Initial Evaluation: $100.00. Subsequent treatments for the same diagnosis: $70.00.

_____ Health Insurance

initials

Primary Insurance Company: _____ Phone #: _____
Plan ID #: _____ Group Number: _____
Policy Holder: _____ Date of Birth: ____ / ____ / _____ SS#: _____ - ___ - _____
Secondary Insurance Company: _____ Phone #: _____

_____ Worker's Compensation

initials

Primary Insurance Company: _____ Phone #: _____
Claim Number: _____ Name of Adjuster: _____
Employer Insuring the Claim & Phone #: _____ (_____) _____ - _____
Date of Injury: _____

_____ Auto Insurance/Med Pay:

initials

Auto Ins./Medpay Company: _____ Phone #: _____
OR
Auto Ins./Lien Company: _____ Phone #: _____
Claim Number: _____ Name of Adjuster: _____
Adjuster Phone #: _____ Date of Injury: _____

Adams & Giddings Physical Therapy, PC accepts auto claims under the following conditions:

1. Medical benefits on the patient's Med Pay are accepted; however, in addition, patient must have:
    a. Private health insurance that will be billed for treatment in the event that the medical on their auto policy is exhausted, or
    b. Patient must pay for treatment at the time of visit with a credit card that will be kept on file for future payments.
2. If patient is using private health insurance, they are responsible for any copay, coinsurance, and/or deductible dictated by their insurance plan.
3. Patients who have a lien with a private company are accepted; however, patients with an attorney lien only, will not be accepted.

I have read the above information and by signing below consent to financial responsibilities, release of information, assignment of benefits, and acknowledgement of privacy practices.

Print Name	**Signature of Patient or Responsible Party**	**Date**

Witness Printed Name	**Signature of Witness**	**Date**

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Statement of Financial Policy

Welcome to **Adams & Giddings Physical Therapy, P.C. (AGPT).** We assure you that you will receive the very best care available for your condition. The following information will familiarize you with the financial policy of this office and how your medical bills will be handled. A copy of this form is available upon request.

Explanation of Insurance Coverage/Insurance Billing: As a courtesy, we can file your insurance claims for you and agree to your insurance company's fee schedule when processing their payment. **We suggest that you contact your insurance carrier prior to your first scheduled appointment to verify physical therapy coverage. Regardless of your insurance coverage, your policy is a contract between you and your insurance carrier. You are ultimately responsible for payment which may include a co pay, coinsurance, and/or deductible. If your claim is denied due to lack of coverage or your insurance company does not pay for the services rendered, you will be responsible for the entire balance on your account.**

Payment Arrangements: Verification of your insurance benefits indicates you are responsible for:

Deductible: $_____ has/has not been met. $_____ payment at each visit.
Co-insurance is: _____ % payment each visit
Co-pay: $_____ payment each visit.

Your portion of the bill must be paid within 30 days of the billing date. Any unpaid balances will be considered past due and will be sent to collections after 75 days. We accept cash, VISA, MasterCard, Discover or check[1].

Appointments: We realize that on rare occasions you may need to reschedule or cancel an appointment. We request that you contact our office as soon as possible if you are unable to attend a physical therapy session. You can contact us at (970) 416-8342 to cancel or reschedule. Please leave a message on our voicemail after hours, if necessary. **If you do not show up for your appointment and do not call to cancel, a $70 fee will automatically be charged to your account balance.**

Authorization for Payment/Assignment of Benefits: I hereby instruct **Adams & Giddings Physical Therapy, P.C.** to bill my insurance company for services rendered and said insurance company to make direct payment of medical benefits to:

Adams & Giddings Physical Therapy, P.C.
702 W. Drake Road, Bldg E, Ste A
Fort Collins, CO 80526

I also understand that should my insurance company send payment to me, I will forward the payment to AGPT within 48 hours. I agree that if I fail to send the payment to the AGPT and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies.

I authorize the AGPT to initiate a complaint to the insurance commissioner for any reason on my behalf and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

_____ initials

[1] A fee of **$25.00** will be charged on all returned checks.

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Release of Information: I authorize any physician, hospital, school, referring agency or other person who has records pertaining to treatment at AGPT to release such records, upon request, to our facility. Furthermore, I authorize AGPT use or release of any of my records it may have to third-party payers, government agencies, healthcare providers, or any other organizations that may assist them in meeting my healthcare needs. I may revoke this authorization in writing at any time and that such revocation will be effective as of the date the written revocation is received by AGPT.

Privacy Notice: You, the below-named patient, are entitled to certain privacy rights regarding protected health information according to the Health Insurance Portability and Accountability Act of 1996 (HIPPA). During the course of treatment, we collect personal information about you that is necessary for treatment. We treat this information as confidential and realize the importance of protecting that information. A complete copy of our HIPPA Privacy Practices is available upon request.

_____ I authorize AGPT to leave messages on my voicemail regarding appointments and other personal information related to my care.

_____ I authorize AGPT to speak with _____ regarding personal information related to my care (*this can be a spouse, family member or trusted confidant that you give permission to relay messages or communicate with us for you*).

_____ DO NOT leave personal/confidential information on my voicemail, only tell me in person or on the phone.

I have read the above information and by signing below consent to financial responsibilities, release of information, assignment of benefits, and acknowledgement of privacy practices.

Print Name	**Signature of Patient or Responsible Party**	**Date**

Witness Printed Name	**Signature of Witness**	**Date**