Hudson Physical Therapy and Wellness

Patient Information Intake

Name: _____
Last **First** **Middle**

Address: _____
Street **City** **State** **Zip**

Phone: Home: ( ) _____ Cell ( ) _____ Work ( ) _____

Email Address:_____ Occupation: _____

Employer: _____ Date of Birth: _____

Preferred Contact Method: _____ (Home / Cell / Work) Can we text you: _____ (Yes/No)

SSN: _____ - _____ - _____ Sex: Male / Female Marital Status: **M**arried/**S**ingle/**W**idowed/**S**eparated/**O**ther

Emergency Contact: _____ Phone:_____ Parent/Guardian: _____

Referring MD: _____ Phone: _____Primary Care MD: _____ Phone: _____

Insurance Company: _____ Name on policy: _____

Insured's Date of Birth: _____ Policy #: _____ Group#_____

Insured's address (If different from patient): _____ Ins. Ph.#:_____

Prescription: _____Yes _____ No (A prescription may be required by your insurance company for payment).

Copy of Insurance cards: _____Yes _____ No

Secondary Insurance: _____ Name on policy: _____

Insured's Date of Birth: _____ Policy #: _____ Group#_____

Insured's address (If different from patient): _____ Ins. Ph.#:_____

Prescription: Yes _____ No _____ (A prescription may be required by your insurance company for payment).

Copy of Insurance cards: ____Yes _____ No

Medicare Only:

Are you currently receiving Home Health Services? _____ If Yes, Name of Agency: _____

Do you have anyone coming into the home to assist with your care? _____ How often? _____

Have you received physical/occupational and/or speech therapy since the beginning of the year? _____

Billing Policy

Hudson Physical Therapy and Wellness can submit claims on an out of network basis to your insurance company. Hudson Physical Therapy and Wellness is not in any network and is considered out of network for all insurance carriers. Please contact your insurance company to ask about your specific coverage for Physical Therapy. Please be aware that your insurance provider may consider some, and perhaps all, of the services rendered not medically necessary. You will be responsible for these charges as well as any out of pocket expenses, deductibles and co-insurances

Consent

I, _____, have read and agree with the above billing policy and authorize payment of medical benefits to Hudson Physical Therapy and Wellness. I understand I am financially responsible for payment of all services received from Hudson Physical Therapy and Wellness. I also understand that I can be charged $25 for appointments cancelled with less than 24-hour advance notice.

HIPPA:

By signing this form I acknowledge that I have received a copy of the HIAA “Notice of Information Practice’s” from Hudson Physical Therapy and Wellness and understand its contents.

Signature Responsible Party: _____ Date: _____

Card#: _____ Security CV # _____

OFFICE: Authorization _____ Deductible _____ Co-ins: _____ Date _____

Notes: