



# Physical Therapy Associates of Schenectady, P.C.

NAME: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ SS#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

PHONE: (H) \_\_\_\_\_ (C) \_\_\_\_\_

(W) \_\_\_\_\_ EMPLOYER: \_\_\_\_\_

DOB: \_\_\_/\_\_\_/\_\_\_ SEX: MALE / FEMALE MARRIED: Y / N EMAIL: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

PRIMARY PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PH: \_\_\_\_\_

REFERRED BY: DOCTOR / FRIEND / FAMILY / OTHER: \_\_\_\_\_

- ▶ If you FAIL to keep your scheduled appointment or do not cancel within 24 hours, we RESERVE the right to charge a \$75.00 fee
  - ▶ Are you currently receiving any type of treatment from a certified home healthcare agency? YES / NO
  - ▶ Have you received any other physical therapy or chiropractic care this year? YES / NO **If YES, please read and sign the following:** I understand that my insurance company may not cover physical therapy if combined with other services such as chiropractic care. I will be responsible for any services denied for this reason.
- SIGNATURE: \_\_\_\_\_

## **PLEASE READ AND SIGN THE AUTHORIZATION BELOW:**

Our office is committed to providing you with the best possible care. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered.

I agree to pay my co-payments (if any) as services are rendered. If for any reason a balance is outstanding on my account, I agree to pay that promptly upon receipt of statement.

I understand that it is my responsibility to be fully knowledgeable of my insurance benefits for physical therapy. It is also my responsibility to inform Physical Therapy Associates of Schenectady, P.C. as soon as possible of any changes to my insurance coverage during my course of physical therapy. Failure to do so may result in additional financial responsibility, owed by me, due to insurance denials based upon claims that are not filed in a timely fashion or filed with inaccurate data.

I authorize Physical Therapy Associates of Schenectady, P.C. to release such information as required by my attorney and/or insurance company to secure my insurance benefits. I understand I will be responsible for services not covered by my insurance company and failure to supply necessary referrals, or prescriptions to secure payment of my account. A photocopy of this authorization shall be as valid as the original.

Should the balance incurred through co-payment, co-insurance, deductible, or other reason remain outstanding for 90 days and I have not made payment arrangements otherwise or have not disputed in writing the balance due, I give authorization for the balance to be charged to my credit card visa/mc/disc/amex # \_\_\_\_\_: expiration date: \_\_\_\_\_. This balance does not include the portion which my insurance company is responsible for.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_