Patient Information/Private Insurance

First Name Initial Last Name Home Phone

Address City Zip Cell Phone

Social Security Number Birth Date Marital Status S M D W Sex M F

Employer Name Address City Zip Telephone

Diagnosis Referring Physician Your E-mail Address

BILLING INFORMATION

Primary Insurance Carrier I.D. Number

Address City/State Zip Phone

Name of Insured if different Relationship to patient Social security number Date of Birth

Attorney Phone Number Date of Injury

Authorization For Payment

I authorize payment of medical benefits to Evergreen Physical Therapy for services rendered to me. I understand that I will be responsible for payment of $50.00 for missed appointments unless I notify Evergreen Physical Therapy at least 24 hours in advance. In addition, I authorize the release of any medical information necessary to process my claims.

Recognition of Possible Symptom Irritability

I understand that physical therapy entails the movement of muscles and joints. For that reason, I understand that on occasion, I may experience increased symptom irritability subsequent to my treatment sessions.

SIGNATURE_____ DATE_____

**********For Office Use Only**********

DATE 1ST CALLED_____DATE FIRST APPT_____

AUTHORIZATION BY:_____DECTUCTIBLE:_____MET?_____PERCENTAGE:_____

MAXIMUM:_____CO-PAY_____REFERRAL NEEDED?_____

EVERGREEN PHYSICAL THERAPY

FINANCIAL RESPONSIBILITY AGREEMENT
PRIVATE INSURANCE

I have a prescription for Evergreen Physical Therapy to provide physical therapy services, and I promise to make payment to Evergreen Physical Therapy for all services rendered.

Although I am responsible for the costs incurred for my treatments, I am aware that Evergreen Physical Therapy will bill my insurance company as a courtesy for services rendered, and I anticipate that all or a portion of the charges made for such services may be paid through my insurance coverage, I agree to pay any co-pays at the time servers are rendered and I understand that upon completion of services, any overpayment will be reimbursed to me by Evergreen Physical Therapy. In the event the insurance company pays their portion of the charges directly to me, I hereby agree that I will immediately pay Evergreen Physical Therapy directly or endorse any such insurance payment to Evergreen Physical Therapy for services provided; and I hereby further authorize and assign payment of insurance proceeds, otherwise payable to me, directly to Evergreen Physical Therapy. I am also aware that insurance does not cover charges incurred by me for missed appointments and I understand that I will be responsible for payment of $25.00 for such appointments unless I notify Evergreen Physical Therapy at least 24 hours in advance.

Should I assert or file a claim against any party or parties responsible in whole or in part for my injury, and should there be any recovery from such claim through judgment, settlement or otherwise, I agree and I hereby authorize and specifically instruct my attorney to pay Evergreen Physical Therapy directly out of the proceeds of such recovery for all charges then outstanding in full (other than those to be paid by insurance coverage), plus interest at the rate of one percent (1%) per month. This agreement is secured by a lien covering any such proceeds received by me as a result of any claim in the for of judgment, settlement or otherwise.

If, for any reason, my insurance coverage is denied or is inadequate, or if any claim I assert or file against the party or parties responsible yields no proceeds form which Evergreen Physical Therapy can be paid, then I am aware that I am nevertheless personally responsible for Evergreen Physical Therapy's bill in full when due, or comply with payment plan arrangements, I agree to pay interest on the unpaid balance at the rate described above. I understand and agree that if, after default on payment, an attorney or a collection agency is retained by Evergreen Physical Therapy to help collect my bill, I will be responsible for all reasonable attorney's fees, collection fees, court costs which may be incurred.

_____ _____

Date Patient or patient's parent or legal guardian

The undersigned attorney for _____hereby acknowledges the authorization the authorization and specific instructions from my client as set forth in this Agreement. I agree to hold the appropriate portion of my recovery resulting from the described claim as constructive trustee for Evergreen Physical Therapy, and to promptly pay Evergreen Physical Therapy the full amount of the then outstanding charges for services rendered to my client plus interest at the time any funds are disbursed from the recovery.

_____ _____

Date Attorney at Law