redbird physio

Preferred name: _____

Name (First, Middle, Last): _____

Gender: ☐ Male ☐ Female Date of Birth (mm/dd/yy): ____ / ____ / ____

Mailing Address: _____

Primary Phone: _____ Secondary Phone: _____

Email: _____

Would you like a reminder for your appointment? ☐ Yes ☐ No

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Retired ☐ Student

Employer: _____ Occupation: _____

Referring Physician: _____ Primary Care Physician: _____

Emergency Contact Name: _____ Phone: _____

How did you hear about us? _____

Insurance Information for which we will be Submitting Claims

☐ Private ☐ Self-pay ☐ Motor Vehicle Accident: Date of Injury ____ / ____ / ____

☐ Workers Compensation: Date of Injury ____ / ____ / ____

Name of Insurance: _____

Name of Insured: _____ Date of Birth: ____ / ____ / ____

Consent to Treat a Minor, Parent/Guardian Information

Redbird Physio is authorized to treat the above listed minor for physical therapy as discussed during initial evaluation.

All statements and/or correspondence will be address to the responsible party and address provided below.

Name of Responsible Party: _____ Relationship: _____

Mailing Address: _____

Primary Phone: _____ Secondary Phone: _____

Print Patient Name: _____

Guardian Signature: _____ Date: _____

Payment Agreement

_____ **(Initial)** I understand that prompt payment for all therapy services is my responsibility regardless of the insurance or other third party coverage

A monthly statement will be sent to you. We accept payment by cash, check, or credit card. All past due accounts over 90 days will be subject to a monthly billing charge. Legal procedures for collection of past due accounts will be initiated if non-payment of account extends beyond 120 days if no arrangements have been made otherwise. The undersigned will be responsible for payment of reasonable attorney fees and all collection costs, including court costs, in the event action is commenced to collect past due accounts.

We are committed to providing the best possible care for you. Our fees fall within the acceptable range by most companies and therefore are covered up to a maximum allowance determined by each carrier. Not all services are a covered benefit in all contracts. To help you receive the maximum benefit from your insurance, we need your assistance and your understanding of our payment policy.

We are happy to process insurance claims and request assignment of private benefits unless you pay in full at the time of treatment, it is your responsibility to understand your insurance policy and coverage. Should insurance payments issued to Redbird Physio, LLC result in a credit balance on your account, monies will be issued to you or your insurance company once course of treatment has been reconciled.

I authorize payment of medical benefits to Redbird Physio, LLC. I have read and understand this payment agreement.

Consent to Treat and Authorization to Release Information

_____ **(Initial)** I voluntarily consent to evaluation and treatment by Redbird Physio, LLC and realize that I have the right to refuse any procedures after having the risks and benefits explained to me. I am aware that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and the treatment results from the rehabilitation therapy.

_____ **(Initial)** I acknowledge that Redbird Physio, LLC may disclose protected health information for the purposes of payment, treatment and healthcare operations (please refer to Redbird Physio, LLC Notice of Privacy Practices for additional information).

_____ **(Initial)** I authorize phone messages and/or emails regarding my treatment and appointments to be left with persons or machines at the phone numbers and/or email address I have provided.

_____ **(Initial)** A copy of this facilities Statement of Privacy Notice has been provided for me to read. A copy will be provided upon request.

No Show and Late Cancellation Policy

_____ **(Initial)** Any patient who fails to arrive for a scheduled appointment without cancelling the appointment at least 24 hours prior to the scheduled time is considered a NO SHOW. A charge of $75.00 will be applied to account and will be due upon receipt of statement. The same fee applies to those patients to fail to cancel their appointment before 24 hours notice of their scheduled appointment time.

Patient Signature: _____ Date: _____

Signature of Responsible Party: _____ Date: _____