



314 East First Street
3229 East Genesee Street

Date ___/___/___

Account Number _____

Patient Name:

(Last) _____ (First) _____ (MI) _____
Email address _____ Do you want to be included in electronic newsletter Y N
Address _____
City _____ State _____ Zip _____
Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____
Employer _____ Work Phone (____) _____ - _____
Employer Address _____
Social Security # _____ Sex M F Birthdate ___/___/___
Marital Status M S D W

Insurance Policy Holder

Name (Last) _____ (First) _____ (MI) _____
Birthdate ___/___/___ Policy Holder SS# _____
Address _____
City/State/Zip _____
Home Phone (____) _____ - _____ Work Phone (____) _____ - _____
Cell Phone (____) _____ - _____
Policy Holder Employer _____
Relationship to Patient _____
Emergency Contact _____ Phone (____) _____ - _____
Referring Physician _____
Address of Referring Physician _____
Phone (____) _____

Accident Information: Work Auto Other Date of Accident ___/___/___

Details of accident _____

Body Part being treated: _____ **Date of Rx** ___/___/___

INSURANCE INFORMATION:

Primary Insurance _____ Phone (____) _____ - _____
Fax (____) _____ - _____ Ins. Address _____
City _____ State _____ Zip _____
ID/Policy/Claim# _____ Group # _____
Effective Date ___/___/___

Secondary Insurance _____
Phone (____) _____ - _____ Fax (____) _____ - _____
Ins. Address _____
City _____ State _____ Zip _____
ID/Policy/Claim# _____ Group # _____
Effective Date ___/___/___



Authorization and Assignment of Benefits

I hereby authorize Championship Physical Therapy, PC to apply for benefits from my insurance carrier(s) listed above and further authorize payment directly to Championship Physical Therapy, PC of the medical benefits, if any, otherwise payable to me for services rendered by Championship Physical Therapy, PC.

Medicare Only: I request that payment of authorized Medicare benefits be made either to me or on my behalf to Championship Physical Therapy, PC for my services furnished to me by Championship Physical Therapy, PC. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I

hereby authorize Championship Physical Therapy, PC to administer any treatment as may be deemed necessary or advisable in the diagnosis and treatment

of _____ (patient). Further, I authorize Championship Physical Therapy, PC to disclose complete information concerning records regarding the illness or accident of _____ (patient) to any collateral source in the case of Medicare, the

Social Security Administration and the Health Care Financing Administration that will pay part or all of said medical bills. I hereby waive on my behalf of myself and any persons who may have an interest in the matter all provisions of law relating to disclosure of confidential medical information. I

understand that all bills for services are due from me when rendered, and I am completely responsible for these charges regardless of any third party interest, payor or the resolution of any legal action or lawsuits in which I may be involved. I further understand that Championship Physical Therapy, PC reserves the right to pursue delinquent accounts via third party collection agencies or attorneys. In the event my bill is referred to collection, I agree to pay the prejudgment interest, reasonable attorney fees, court costs and service of process costs to said physical therapist in addition to the amount owed for the services rendered.

Estimated Portion Due from Patient:

This Authorization and Assignment of Benefits is valid for all episodes of care rendered by any and all physical or therapists and/or physical therapist assistants associated with Championship Physical Therapy, PC .

X _____

Signature of Patient or Guarantor, if Minor Date Witness



Notice of Privacy Practices

In accordance with HIPAA privacy regulations, we are notifying you as to how medical/protected health information about you may be used and disclosed. Under the law, we are required to maintain the privacy of this information, but may need to share protected health information (PHI) to others in order to process your claim or for health care operations, which may include but are not limited to: 1) Receive Payment, 2) Verify Insurance, 3) Conduct Quality Assessment, 4) Care Coordination/Management, 5) Manage Our Business, 6) Assist Other Covered Entities With Their Health or Business Operations, 7) Accreditation, Certification, Licensing, or Credentialing, 8) Disclosure to the Secretary of the United States Department of Health & Social Services, 9) Health Oversight Agencies, 10) To prevent a serious threat to Health or Safety, 11) Research, 12) Workman's Compensation, 13) Public Health & Safety, 14) Legal, National Security or Law Enforcement, 15) Personal Physician, Team Physician, Athletic Director or Coach, 16) To you or your Designee upon written request, 17) Other uses and disclosures of PHI only after your written authorization.

All Evaluations, Progress Notes as well as significant changes in Medical Conditions will be reported via Fax, Phone, and or Mail to your Referring Physician and possibly Primary Care Physician. All insurances will be verified with pertinent PHI being released to the Insurance Company(s) necessary to process claims. All patients will be asked to sign in at the Front Desk upon arrival and names will be announced. Part of treatment is performed in an open environment. Some claims are billed electronically. If you wish not to sign on the sheet, not to have your name announced, not to bill claims electronically, or not to be in an open area for treatment, please notify the receptionist immediately and we will attempt to make alterations to accommodate your needs. If you have any questions, please ask to speak to the Physical Therapist.

Thank You,

Patient Signature

Date