PENINSULA PHYSICAL THERAPY & ASSOCIATES, INC
1618 HARDY CASH DRIVE, HAMPTON, VA 23666

PATIENT INFORMATION

Patient's Legal Name: (LAST) _____ (First) _____ (M) ____

Home Address: (Street) _____

City _____ State _____ Zip _____

Home Phone: _____ Cellular: _____ Work: _____

Date of Birth _____ Age _____ Social Security # _____

Patient's Sex (Circle One) Male Female Marital Status (Circle One) S M D W

Employer' Name: _____

Employer Address: _____ City/State/Zip: _____

Referring Doctor: _____ Phone: _____

Responsible Party (Guarantor): _____ SS# _____

Are your injuries related to an accident? **YES** **NO** **Date of Onset/ Injury: _____**

Primary Insurance	**Secondary Insurance**
Name:	Name:
Address:	Address:
Policy #	Policy #
Group #	Group #
Name of Insured:	Name of Insured:
Insured's Date of Birth: Sex	Insured's Date of Birth: Sex
Insured's SS#:	Insured's SS#:

I understand that I will be expected to make my Co-Pay/ Cost Share prior to each visit.
I hereby acknowledge receipt of PPT&A's "Privacy Promise".

Patient / Guarantor Signature: _____ Date: _____

Name of Parent/ Guardian (For Minor Patients) _____

Please Sign Consent Form On The Back

For Company Use Only

☐ New Patient ☐ New Diagnosis ☐ Update

Diagnosis _____ Chart # _____ Date: _____

PAYMENT POLICY & BILLING PROCEDURES

Unless 100% coverage has been verified, you are responsible for the percentage, co-pay and/or deductible not covered by your insurance company. This payment is requested before each visit.
If insurance information is not available or you do not have insurance, payment is due in full unless other arrangements have been approved by the Business Office
You will receive a monthly statement, which will show you the status of your account.
There is a $30.00 charge for all returned checks.
If collection procedures are required, you agree to the cost of collection including 38% of the unpaid balance as attorney's fees and court costs. _____ (initial)

INSURANCE INFORMATION

As a courtesy to our patients, we will verify and file your insurance; however, we cannot guarantee payment. We strongly suggest that you read your policy manual as it pertains to physical therapy coverage. Many insurance companies have stipulations, such as usual and customary fee (UCR), limited Therapy sessions, limited reimbursable amounts per session, deductibles, co-payments, supplies, etc. Such stipulations should be indicated in your policy manual.
YOU ARE RESPONSIBLE FOR AMOUNTS NOT COVERED by your insurance. We have an agreement with YOU, not your insurance company, for receipt of payment. Please be aware of this and plan to make payments accordingly.
Worker's Compensation benefits will be verified; however, this does not guarantee payment. In the event of denial, this account will become YOUR RESPONSIBILITY. _____ (Initial)

CONSENT TO TREAT – RELEASE OF INFORMATION

I understand that I have been referred for rehabilitative treatment and care to Peninsula Physical Therapy & Associates, Inc, hereafter referred to as PPT&A, Inc. PPT&A, Inc. has described for me my individual treatment plan. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that has been prescribed by my physician and/or recommended by my therapist. By signing this agreement, I consent to have PPT&A provide treatment and care as prescribed by my physician and/or recommended by my therapist.

The statements are true and complete to the best of my knowledge. I understand, fully, the payment policy/billing procedures by PPT&A. I hereby authorize PPT&A to furnish my insurance company(s), case manager, attorney, or legal representative all information, which said parties might request concerning my present illness or injury. I hereby assign PPT&A, Inc. all money to which I am entitled for medical expenses related to the service reported herein, but not to exceed my indebtedness with PPT&A. It is also understood that any money received from the above named parties over and above my indebtedness will be refunded to me when my bill is paid in full. I understand that I am financially responsible to PPT&A, Inc. for charges not covered by my insurance company. I certify by my signature that I have read and agree to this information.

Signature	Date

Relationship to Patient (self, parent, guardian, spouse, other)

EMERGENCY CONTACT INFORMATION

Emergency Contact Name	Phone Number (incl. area code)
Relationship to Patient	