316 Portland Rd Ste 203
Bridgton, ME 04009
Tel: (207) 647-2727
Fax: (207) 647-2734

Patient Data Sheet

MR #:_______________

Please Print

YOUR CONTACT INFORMATION

Name: ______________________________ **DOB:** ______/______/______ **SSN:** ________________

Mailing Address: ______________________________________ **Gender: M F**

Physical Address: ______________________________ **E-mail:**________________

Do we have your permission to send you our E-News Newsletter? Y N

Phone Numbers: Home: ______________ **Cell:** ______________ **Work:**________________

How can we contact you? (circle all that apply): ***E-mail*** ***Home #*** ***Cell #*** ***Work #***

Your Employer*:* ______________________________ ***Address:*** ________________________

EMERGENCY CONTACT: ______________________________ ***Telephone:***________________

If Under 18 Years of Age: Responsible Party Name: ______________________ Relationship to you: ______________

Address (if different from patient): ______________________________ Telephone:: ________________

Please Select the 'BEST' reason on why you chose Premier PT as your physical therapy provider

Friend / Relative Recommendation
Convenience (circle one): Location; hours of operation
You have been treated here before

Saw our advertising (circle one): newspaper; sign; phonebook; community sponsored event
Website
Doctor's Recommendation
Other: ____

Your Diagnosis– What are we seeing you for? ______________________________ Onset Date: ________________

Doctor Sending you to PT: ______________________ Family Doctor (Primary Care Physician) ________________

BILLING / INSURANCE— Whom do we bill ? (Please Check Appropriate Category)

Health Insurance __ Worker's Comp __ Auto Insurance __ Self Pay __

Primary Insurer: (Name of Insurance) ____

Subscriber's Name: ______________ ID/ Certificate/ Policy Number: ______________________ Group #: __________
Subscriber's Date of Birth: ______________ Your Relationship to the Subscriber: ______________________

Secondary Insurer: (Name of Insurance) ____

Subscriber's Name: ______________ ID/ Certificate/ Policy Number: ______________________ Group #: __________
Subscriber's Date of Birth: ______________ Your Relationship to the Subscriber: ______________________

Workers Comp or MVA (Name of Insurance)______________________ Telephone: ______________________
Claim Handler's Name ______________________ File / Claim # ______________________

If you are represented by an attorney for litigation

Attorney name ______________________ Address ______________________________ phone ______________

CONTINUED ON BACK

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent and authorization for Premier Physical Therapy LLC, to provide examination, treatments, and services by a physical therapist to myself/designee:

I realize and certify that no guarantee or assurance has been made as to the results that may be obtained for such examinations, treatments, and services.

ASSIGNMENT AND RELEASE

I hereby authorize my insurance company to pay benefits directly to Premier Physical Therapy LLC, or its designee, for services rendered and agree that I am financially responsible for non-covered services. I also authorize Premier Physical Therapy LLC,PA, to release any and all requested information pertaining to treatment necessary to process a claim(s) for physical therapy benefits. (Physician, Insurance company, Attorney etc)

FINANCIAL POLICY STATEMENT

It is our policy to bill your insurance carrier as a courtesy to you, although you are responsible for the entire bill when services are rendered. Questions and/or concerns about the bill and payment policies should be directed to our Billing Department, at 866-533-8175

Evidenced by my signature below, I agree to pay any balance of the provider service charges over and above the insurance coverage. I understand that account balances remaining due 90 days and more after the date services were provided will be subject to a 1.5% finance charge per month and any cost incurred in the recovery of those charges including collection costs and reasonable attorney's fees will be my responsibility. Customized payment programs may be available on a pre-arranged basis.

I understand and authorize Premier Physical Therapy LLC, PA, to bill my health insurance if a claim is contested, or remains unpaid after 30 days from submission, by my Worker's Compensation or Liability Coverage. Further, if my claim is covered under liability coverage (due to accidental injury and/or motor vehicle accident), I authorize my attorney and/or the responsible party to make payment in full directly to Gray Physical Therapy on my behalf. I understand that if I settle a case with Workers' Compensation or a Third Party Liability Insurer, it is my sole responsibility to ensure that my claims have been paid in full by the insurer, or that I will be responsible for paying the entire balance personally.

I understand that it is my sole responsibility to understand my insurance coverage, and that I will independently verify my physical therapy benefits with my insurer. Any balance that remains unpaid after my insurer has processed my claims, minus any contractual discount that Premier Physical Therapy LLC is required to extend to me, is my full responsibility.

I have read the above information and understand that ultimately it is my sole responsibility for the payment of my account.

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS AND RESPONSIBILITIES

I, ___________________________, have been provided access to, and have been offered a copy of, the notice of privacy practices followed by Premier Physical Therapy LLC, PA. I was also provided with a copy of the summary of the Privacy Practices and Patient Rights and Responsibilities followed by Premier Physical Therapy LLC, PA. I have read and understand the Consent for Care and Treatment; Assignment and Release and Financial Policy Statement as set forth above. I have had an opportunity to read all these documents and ask questions. I consent and agree to all the terms and conditions as set forth in these documents.

Signature of Patient:____

If patient is a minor, Signed for Patient by: ____________________________________ (Relationship): ___________________

Today's Date: ________________________________ Witness: ____