SPORTSMED PHYSICAL THERAPY

Patient Information

Patient Name: _____ Date of Birth: _____ **M / F** Visit Due to Auto Accident: **Y / N**

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____)_____ Work Phone: (_____) _____ Cell Phone: (_____)_____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed Email: _____

Spouse or Other Emergency Contact: _____ Phone: (_____)_____

(If Minor) Responsible Parent: _____ Phone: (_____)_____

Responsible Party Primary Insurance

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____)_____

Responsible Party Secondary Insurance

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name:_____ Date of Birth:_____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____)_____

Workers Compensation Information

Employer: _____ Work Phone: (_____)_____

Employer Address: _____ City: _____ State: _____ Zip: _____

Claim #:_____Date of Injury:_____

Insurance Name: _____ Adjuster's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone:(_____)_____ Fax:(_____)_____

Auto Accident Information

Auto Insurance: _____ Claim# _____ Date of Injury: _____

Adjuster: _____ Phone:(_____)_____ Fax: (_____)_____

I hereby assign all physical therapy benefits, to which I am entitled, Medicare, private insurance and other health plans to: Sportsmed Physical Therapy, 1551 South Renaissance Towne Drive, Suite 420, Bountiful, UT 84010. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment, via Fax transmittal or hard copy.

STATEMENT OF FINANCIAL RESPONSIBILITY:

The patient/responsible party is responsible for all medical bills that result from services rendered by Sportsmed Physical Therapy, Inc.
Please remember that insurance is considered a method or reimbursing the patient for fees paid to the therapists and is not a substitute for payment. Some companies may pay fixed allowances for certain procedures, sometimes referring to theses as "Reasonable and customary fees." We do not accept this as payment in full, unless otherwise restricted by law or contract agreement we may have with your insurance carrier. Many insurance companies pay only a percentage of the charge, leaving it your responsibility to pay any deductible amount, co-insurance amount and any other balance not covered by your insurance. Patient portion should be paid at the time of service.

INJURIES AT WORK: In the event it is determined by Workman's Compensation board, that the illness is not a result of a compensated Workman's Compensation case, you will be responsible to pay usual and customary fees for services rendered.

AUTO INSURANCE CLAIMS: will be billed to auto carrier, if auto has been exhausted; we require primary insurance information at time of service. Patients without insurance will be required to pay at time of service.

Interest of 1.5% per month (18% per year) will be applied to any amount not paid after 30 days with a minimum charge of 50 cents per month

X _____
Signature of Responsible Party

X _____
Date