O'Neill Physical Therapy -- Insurance & Billing Information

Patient Name: ________________________________ M/F/Other Date of Birth____/_____/______

PRIMARY INSURANCE COMPANY: ____

Policy number: ______________________________ Group number: __________________

SECONDARY INSURANCE COMPANY (if applicable): ______________________________

Policy number: _____________________ Group number: ______________________________

** Your primary/secondary insurance MUST be listed in the order that it should be billed. Any changes with insurance must be reported to front office or insurance office ASAP. If correct insurance is not given, patient may be responsible for charges.

In the past two months, have you or are you currently receiving health care services at home? Nurse and/or Aide?

YES_____ NO______ If YES, please tell receptionist NOW. Thank you!!

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Is your visit today a result of a current Motor Vehicle Accident Claim NO ________ YES*** _________

Is your visit today a result of a current Workers Compensation Claim NO _________ YES ___________

If you have answered yes to either question above please fill out below information.:

Date of accident/injury: _________________ Claim # _________________________

ADJUSTER/CASE MANAGER NAME ____________________________ Direct Phone Number: _______________

Insurance company______________________ Phone #_____________________

*** If we are billing your Motor Vehicle Insurance, please also provide personal insurance information.

We will ONLY bill your personal insurance IF or WHEN PIP coverage has been exhausted.***

By signing below, I hereby attest that I have provided all insurance coverage applicable for services performed at this time. In the event that there is insurance coverage requiring pre-certification and it is not disclosed at the time of service, I will be held responsible for any outstanding balance. I understand that I am responsible for notifying O'Neill Physical Therapy if my insurance coverage changes, if I fail to notify them, I will be financially responsible for any services that are not covered by insurance. I understand that I am responsible for co-payments and deductibles at the time of service. I understand failure to pay the co-payments and deductibles will result in cancellation of my appointment and that I will be charged the cancellation fee. I understand that the charges may be more than my insurance company will cover and I am responsible for the balance due on my bill.

I authorize O'Neill Physical Therapy to release information from patient records to any insurer of the patient and to the other agencies or individuals providing medical or social services to the patient. Consent is given for the release of information and records to O'Neill Physical Therapy from all other agencies or individuals from where the patient has received medical or social services. I hereby authorize the insurance company or law firm representing me to pay "O'Neill Physical Therapy directly for services I receive.

INFORMED CONSENT: I am aware that I am undergoing physical therapy. Benefits may include relief of pain and improvement of function. Risks may include temporary aggravation of symptoms, pain or other adverse effects. Should I note a change in my symptoms, I am responsible for informing my physical therapists. I consent to treatment including, but not limited to, therapeutic exercise, electric stimulation, hot packs, cold pack, ultrasound, gait training, functional training, taping, paraffin, biofeedback, traction, iontophoresis, joint and soft tissue mobilization and manipulation.

I acknowledge having had the opportunity to review and receive a copy of O'Neill Physical HIPPA privacy policies.

Please sign and date:

Signature: ____ Date: ______________