

**WELCOME TO FUNCTION BETTER PT
HERKIMER, YORKVILLE, UTICA**

Please provide the necessary information below as accurately as possible so that we may correctly process insurance billing. Please ask our office staff if there are any questions or concerns. Thank you for choosing Function Better, PT.

Patient Information

Name _____ Date _____
Street _____ Apt # _____ City _____ State _____ Zip _____
Telephone (home) (____) _____ - _____ Work (____) _____ - _____
Email Address _____
Date of Birth ____/____/____ Sex (circle one) M F Marital Status (circle one) M S D W
Social Security # _____/_____/_____
Emergency Contact _____ Contact Phone # (____) _____ - _____
Referring Doctor _____ Date of last visit ____/____/_____
Address _____ Office Phone (____) _____ - _____
Primary Care Physician _____ Office Phone (____) _____ - _____
Address _____
Date /Onset of Injury ____/____/____ Type of injury/pain _____
Are you currently receiving services from a Home Health Agency? (circle one) Yes No
Is this injury Workers Compensation or Auto Related? (circle one) Yes No Specify _____
Employer Name (if employed) _____
Address _____ City _____ State _____ Zip Code _____
Are you currently working? (circle one) Yes No Last date of work ____/____/____
Supervisor Name _____ Phone (____) _____ - _____

Insurance Information

Ins. Carrier _____ ID# _____ Group # _____
Address _____ Phone (____) _____ - _____
Insured's Name _____ SSN _____ - _____ - _____ DOB ____/____/_____
Insured's Employer _____ Phone (____) _____ - _____
Address _____
Additional Information (WCB # , Carrier Case #, etc) _____

Secondary Insurance Information (if applicable)

Ins. Carrier _____ ID# _____ Group # _____
Address _____ Phone (____) _____ - _____
Insured's Name _____ SSN _____ - _____ - _____ DOB ____/____/_____
Address _____

I authorize the release of all medical information necessary to process my medical claims. I also authorize my insurance company to make payment directly to Function Better, PT for services rendered to the above named patient. I understand that I am fully responsible for all charges incurred for treatment rendered to the above name patient.

Signature _____

Date on Initial Evaluation ____/____/____ Time _____ PT _____

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Scheduling, Prescription, Insurance, and Medical Records Policies

We have found the communication with our patients regarding our policies assists us in providing the best service to you. Please take that time to carefully read the sections, which pertain to you.

SCHEDULING – We will make every effort to schedule an appointment at the most convenient day and time for you. Remember, it is important that you call at least 24 hours in advance to cancel an appointment so to accommodate your busy schedule. We suggest that you schedule your appointments two or three weeks in advance, whenever possible. This is for your convenience as well as ours.

PRESCRIPTIONS – In order to be treated, you must first have a valid prescription from a New York State Licensed Physician for physical therapy. It is the patient’s responsibility to ensure the prescription is up-to-date and valid.

INSURANCE – We are happy to bill your insurance company as a courtesy and convenience if we are provided with the appropriate billing information. If we do not receive proper information, payment may be required at the times services are rendered. *Please Note: It is your responsibility to know your insurance policy coverage in regards to physical therapy services.* In the event your insurance company forwards payment for physical therapy services to you, you will deliver such payment to Function Better PT immediately.

NO INSURANCE – We are happy to provide service to patients not participating in a health insurance program, but we must insist payment be made at the time services are rendered.

MEDICAL SUPPLIES – The patient will be responsible for the cost of any durable or medical goods supplied by Function Better PT in the event that the insurance carrier does not cover these expenses.

AGREEMENT AUTHORIZATION

Patients medical records are considered private and confidential and we value our patients privacy. However, it may be necessary to provide copies of a patient’s chart to insurance companies and/or attorneys to settle a dispute or facilitate payment. In order for us to provide this information, we must have your authorization. Without authorization, your account may remain unpaid and we may bill you directly for continued unpaid balances.

I understand and agree that I am financially responsible and liable for payment of all charges assessed to me for professional services rendered by Function Better PT. I understand that I am ultimately responsible for all charges regardless of my existing medical coverage. In the event that my insurance company forwards payment for physical therapy to me, I will deliver such payment for physical therapy immediately.

I understand and agree that it becomes necessary for Function Better PT to commence any legal action or obtain an attorney for collection of any outstanding charges on my account, I will be responsible for all reasonable fees incurred by physical therapy in addition to such balance.

Signature

Date