

# Patient Information Form

Name: \_\_\_\_\_ Hm Phone: \_\_\_\_\_

Employer: \_\_\_\_\_ Wk Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ email address: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Wk Phone: \_\_\_\_\_

Nearest Relative not living with you: \_\_\_\_\_ Phone: \_\_\_\_\_

Nearest friend not living with you: \_\_\_\_\_ Phone: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Landlord: \_\_\_\_\_ Phone: \_\_\_\_\_

Whom may we contact in the case of an emergency?

\_\_\_\_\_ Phone: \_\_\_\_\_

Whom may we thank for referring you to us?

\_\_\_\_\_ Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Who is responsible for this bill? \_\_\_\_\_

I will be paying today by: cash \_\_\_\_\_ check: \_\_\_\_\_ credit card: \_\_\_\_\_

*I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent (if minor)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

## **WELCOME TO SKYLINE PHYSICAL THERAPY SERVICES**

*We are committed to providing you with the best possible care. If you have medical insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.*

*If you have insurance, we will be happy to file your insurance claims, however, it is your responsibility to make sure the claims are being paid in a timely manner. While we are able to verify insurance coverage, most insurance carriers will not guarantee payment until they receive the claim and diagnosis. Your coverage may be subject to limitations and we encourage you to check with your insurance company regarding your particular plan.*

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### **MEDICARE GUIDELINES**

*If you have received home health or outpatient physical therapy through another clinic, please advise us.*

*A written referral signed and dated by your physician is required. There must be evidence in the clinical record maintained by the therapist that a physician has seen the patient at least every 90 days. Therefore, it is the patient's responsibility to make an appointment with his/her referring physician every 90 days from the date of the initial evaluation, in order for Medicare to reimburse for the services rendered.*

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*We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.*

***Payment is due at the time services are rendered unless payment arrangements have been approved in advance by our staff.** This includes charges not covered by insurance, co-pays, and durable medical equipment. Deductibles and coinsurance will be billed. They are due at the time of receipt and will be mailed on the 1<sup>st</sup> and the 15<sup>th</sup> of every month. If you are unable to pay the full amount, a payment plan may be arranged for you. We accept cash, check, or credit card.*

***Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1.33% per month.** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.*

*If you have any questions, **PLEASE** do not hesitate to ask us. We are here to help you and appreciate that you have chosen our clinic for your care.*

**Thank you,  
Skyline Physical Therapy Services**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent (if minor)

\_\_\_\_\_  
Date

**PLEASE COMPLETE THE REGISTRATION ON THE OTHER SIDE**