# KING PHYSICAL THERAPY

**Welcome to King Physical Therapy. Please, let us know if we can assist you as you answer the following questions. We hope your experience with us will be pleasant.**

## PATIENT DEMOGRAPHICS

Today's Date: _________ Patient's Full Name: ______________________________________

D.O.B.: _______________ Gender: M F SSN: _______________________________

Street Address: ____________________________________ City: ______________________

State: ___________ Zip: ___________ Email Address: ______________________________

Home Phone: _______________ Work: _______________ Mobile: ___________________

Employer/School: ____________________________ Occupation: ____________________

Employer's Address: ________________________________________________________

Emergency Contact: _______________________________ Relationship: ______________

Home Phone: _______________ Work: _______________ Mobile: ___________________

Name of Insured (if different): _____________________________________________

Insured's SSN: _________________________ Insured's D.O.B.: ______________________

## INJURY OR ILLNESS RELATED INFORMATION

Date of onset/injury: ______________ Is this a work related injury? Yes No

If yes, has your treatment been approved by workers compensation? Yes No

Worker's Compensation claim number: _____________________________State: _____

Address where claims are to be mailed _________________________________________

Is this an auto-related injury? Yes No

If yes, has your treatment been approved by your auto insurance? Yes No

Claim Number: _______________________ Insurance Name: ______________________

Is this case under litigation? Yes No Attorneys Name: _______________________

Referring Physician: ____________________ Date Last Seen: _______________________

Primary Physician: ______________________ Date Last Seen: _______________________

**Who/what influenced you to choose KPT for your rehabilitation?**

Physician: __________________ Friend or Family ___________ Brochure: ___________

Newspaper: _________________ Phone Book: _______________ Other: _______________

# King Physical Therapy

**Financial Policy for Automobile Accidents:**

We would like to thank you for entrusting your health to us! We will do everything we possibly can to assist you in your recovery from your automobile accident. In attempts to help you settle your claim, we will provide all notes and bills to your insurance carrier as requested and your attorney as applicable.

It is your responsibility as the patient to provide us with any information regarding your insurance carrier, claim number, attorney, or any changes that may occur during your treatment at King Physical Therapy.

Payment for your treatment will be due at the time of your treatment. This may occur in one of three ways:

- Payment through your own PIP (personal injury protection) coverage of your auto insurance. We will bill your auto insurance as long as you have PIP coverage.
- Use of your medical insurance – If you have medical insurance coverage, we will bill all of your treatment to that insurance company as per their guidelines, once all of your PIP has been exhausted. We will verify your coverage and benefits upon your first visit and review them with you. You will be responsible for all deductibles and co-pays per your specific health plan.
- Private pay – If you do not have medical insurance coverage, we will require payment for your services upon each visit at our full charge per CPT code. We accept cash, check, Visa, or Mastercard.

Once your claim has been settled with your automobile insurance carrier, they will reimburse you for your expenses incurred for treatment, based on your settlement agreement with them.

I have read and understand the above policy. I understand my financial obligations to receive treatment at King Physical Therapy for my injury sustained in my automobile accident.

________________________________ ________________

Signature Date

# King Physical Therapy

## AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize release of my individually identifiable health information for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that I receive. Continuity of care is part of treatment and my records may be shared with other providers to whom I am referred from or referred to. This information may be shared by paper mail, electronic mail, FAX, or other methods. I understand that my healthcare and the payment for my healthcare will not be affected by signing this form.

I have been given a copy of the **King Physical Therapy Patient Privacy Policy.** I also understand that I may revoke this authorization at any time in writing, but it will not have any affect on any actions they took before they receive the revocation.

______________________________________ ______________________

**Signature of Patient or Responsible Party** **Date**