**Professional Physical Therapy**
**216 N 2nd Street**
**Amite, LA 70422**
**Phone 985-748-7878**
**Fax 985-748-2837**

# PATIENT INFORMATION

ACCT #_____

DX CODE(S) _____

Title _____ Name _____
FIRST MI LAST

Mailing Address_____City_____State_____Zip_____

DOB _____ Gender *(Circle)* Male Female SSN _____ DL# _____

Home _____ Cell _____ Work/Other _____

Email _____ Preferred Contact *(Circle One)* Home Cell Work Email

Employed (*Circle)* Yes No Employer _____ Phone _____

Emergency Contact _____ Phone _____

Referring Doctor _____ Phone _____ Fax _____

NPI _____

***Who is responsible for bill?***

Name _____ Relationship to Patient _____

Address _____City_____State_____Zip_____

_____ _____
**SIGNATURE OF RESPONSIBLE PARTY** **DATE**

*Have you had Physical Therapy, Occupational Therapy, or Speech Therapy at any other clinic within this calendar year?* YES NO

*If so, was it Physical Therapy, Occupational Therapy, or Speech Therapy?*_____

*If so, what dates were you treated?* _____ *How many visits did you have?*_____

*Are you receiving home health for any of these services?* YES NO

*What facility were treatments rendered?*_____

**PROFESSIONAL PHYSICAL THERAPY A PROFESSIONAL CORPORATION**
DBA AMITE PHYSICAL THERAPY
216 NORTH SECOND STREET, PO BOX 398
AMITE, LA 70422
**FINANCIAL POLICY**

***PLEASE READ, ANSWER ALL QUESTIONS, AND SIGN WHERE INDICATED***

## RELEASE OF INFORMATION

Permission is hereby granted to Professional Physical Therapy, to release all medical billing information concerning my physical condition to my insurance company, representatives or my attorney at law.

Professional Physical Therapy has accepted assignment of insurance benefits for your treatments.

If you have health insurance, it should be understood that this is an agreement between you and your insurance company and not an agreement with Professional Physical Therapy. Your therapy bill is an agreement between you and Professional Physical Therapy. You are responsible for the payment of your bill regardless of the status of insurance claim. Professional Physical Therapy provides full claim-filing services. PPT files insurance claims on a weekly basis. As a convenience to me and said corporation it is hereby given my consent to file claims on said policy and to do such other actions as it deems necessary in connection therewith so as to promptly obtain payment under said policy.

This date I have contracted with PPT for the furnishing of services rendered or to be rendered, I will be responsible for payment of total bill incurred as a result of treatment received. Although I may choose to use insurance coverage to pay all or any portion of the bill incurred, I understand that the filing of insurance forms does not constitute payment of any portion of the bill, and I understand that I am responsible for all charges billed to me for treatment of above patient. I accept full responsibility for payment of the total balance of my account.

**I have this date assigned to Professional Physical Therapy, the benefits due under my existing policies of insurance. I direct my insurance company to pay Professional Physical Therapy, direct without payment to me. I agree to permit a copy of this assignment to be used in place of the original.**

***Please understand that this is not a guarantee of payment by your insurance company. The ultimate obligation for payment rest with the patient and/or the responsible party if patient is a minor.***

In most cases our claims will arrive at your insurance company before other hospital or physician claims. Therefore, any unpaid deductibles must be paid at each visit.

***IF THIS IS NOT AN ATTORNEY OR AUTO INSURANCE CASE (LIABILITY CASE) AND LATER BECOMES ONE OR THE OTHER, YOU MUST NOTIFY PROFESSIONAL PHYSICAL THERAPY***

If unusual circumstances should make it impossible for you to meet our credit terms, we invite you to call or personally discuss the matter with our credit department. This will avoid misunderstandings and enable you to keep your account in good standing. Except when hardship warrants otherwise accounts 90 days past due will be referred to our collection agency or attorney for further action.

If it becomes necessary for my account to be referred to an attorney or collection agency for collection or suit, then I agree to pay reasonable attorney fees or collection fees together with all costs associated with collection.

**I, the undersigned, have read and understood the above credit policy and hereby agree to terms therein.**

_____ _____

PATIENT/PARENT OR GUARDIAN SIGNATURE DATE