PATIENT INFORMATION

Date: _____/_____/_____ Social Security #: ________________________________

Name: ______________________________________ Date of Birth ____/_____/_____ Home Phone: ______________________
first middle initial last

Email Address: __________________________ Work: ________________________ Cell Phone: _________________________

Address: ____
street city state zip code

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Sex: ☐ Male ☐ Female

Referring Doctor: ____ Primary Care Doctor:____________________________

Who is responsible for payment: (excluding your insurance) ____

Your Employer: _____________________ Employer's Address: ____
street city state zip code

Occupation: ____ Driver's License #: ______________________________

Spouse or Guardian's Name: __________________________________ Emergency phone. #: __________________

RELEASE OF INFORMATION • PAYMENT AGREEMENT • CANCELLATION/NO SHOW

1. **RELEASE OF INFORMATION**

I hereby authorize Cupertino Physical Therapy, Inc. to release information to:

Physician	PRIMARY Insurance
Other/Primary Care Physician	Secondary or Supplemental Insurance

We are committed to providing the best possible physical therapy care for you. Our fees fall within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier. Not all services are a covered benefit in all contracts. To help you receive the most benefit from your insurance, we need your assistance and your understanding of our payment policy.

2. PAYMENT AGREEMENT: I understand that payment for all physical therapy services is my responsibility regardless of insurance or other third party coverage.

Payment is due at the time service is rendered unless special arrangements are made. With the development of an account balance, a monthly statement will be sent to you. We accept payment by cash, check.

We will be happy to process your insurance claims and request assignment of private insurance benefits unless you pay in full at the time of treatment. It is **your** responsibility to understand **your** insurance policy and coverage; if special authorization is needed for physical therapy it is **your** (the patient's) responsibility to obtain it from your insurance company.

3. CANCELLATIONS/NO SHOWS: If during the course of treatment, I must cancel a scheduled appointment. I will notify Cupertino Physical Therapy, Inc. no less than **24-hours** before the time of the appointment. If I fail to give notice of cancellations, I understand that a **$50 fee** will be charged and I am responsible for payment of that fee, not my insurance company.

AUTHORIZATION FOR MEDICAL TREATMENTS AND FINANCIAL AGREEMENT: I authorize medical payment directly to Cupertino Physical Therapy, Inc.. I/We do hereby consent to and authorize the performance of all treatments, by the physical therapist and staff which they may deem advisable and agree to pay all charge incurred by reason thereof. I also hereby authorize release of information requested by my insurance company and/or its representatives. I fully understand that this agreement and consent will continue until cancelled by me in writing.

____

Signature of Patient or Guardian Date

MEDICARE AND HEALTH INSURANCE CLAIMS, FILL OUT THIS SECTION

MEDICARE PATIENTS ONLY: We bill Medicare for you. Medicare pays 80% of the approved amounts for physical therapy treatments. Medicare does not allow us to write off any portion of the 20% co-pay or deductible. If you have a secondary or supplemental insurance, we will bill for you. If you do not have a supplement, you will be responsible for the 20% and we ask that you make those payments during the course of your treatment.

Name: ____ Medicare Number: ___________________________

I request that payment of authorized Medicare benefits be made to Cupertino Physical Therapy, Inc. for any services furnished by my provider. I authorize any holder of medical information about me to be released by Medicare and (my secondary or supplemental insurance) any information needed to determine these benefits payable for physical therapy services. I understand my signature requests that payment be made to Cupertino Physical Therapy, Inc. and authorize release of medical information necessary to pay the claim. I do hereby consent to and authorize the performance of all treatments, by the physical therapist and staff which they may deem advisable and agree to pay all charges incurred by reason thereof.

____

Signature of Patient Date