316 Portland Rd Ste 203
Bridgton, ME 04009
Tel: (207) 647-2727
Fax: (207) 647-2734

PREMIER Physical Therapy
Lakes Region

Patient Data Sheet

MR #:_____

Please Print

YOUR CONTACT INFORMATION

Name: _____ **DOB:** _____/_____/_____ **SSN:** _____

Mailing Address: _____ **Gender: M F**

Physical Address: _____ **E-mail:**_____

Do we have your permission to send you our E-News Newsletter? Y N

Phone Numbers: Home: _____ **Cell:** _____ **Work:**_____

How can we contact you? (circle all that apply): ***E-mail*** ***Home #*** ***Cell #*** ***Work #***

Your Employer: _____ ***Address:*** _____

EMERGENCY CONTACT: _____ ***Telephone:***_____

If Under 18 Years of Age: Responsible Party Name: _____ Relationship to you: _____

Address (if different from patient): _____ Telephone:: _____

Please Select the 'BEST' reason on why you chose Premier PT as your physical therapy provider

Friend / Relative Recommendation
Friend's Name: _____
Convenience (circle one): Location; hours of operation
You have been treated here before

Saw our advertising (circle one): newspaper; sign; phonebook; community sponsored event
Website
Doctor's Recommendation
Other: _____

Your Diagnosis– What are we seeing you for? _____ Onset Date: _____

Doctor Sending you to PT: _____ Family Doctor (Primary Care Physician) _____

BILLING / INSURANCE— Whom do we bill ? (Please Check Appropriate Category)

Health Insurance __ Worker's Comp __ Auto Insurance __ Self Pay __

Primary Insurer: (Name of Insurance) _____

Subscriber's Name: _____ ID/ Certificate/ Policy Number: _____ Group #: _____
Subscriber's Date of Birth: _____ Your Relationship to the Subscriber: _____

Secondary Insurer: (Name of Insurance) _____

Subscriber's Name: _____ ID/ Certificate/ Policy Number: _____ Group #: _____
Subscriber's Date of Birth: _____ Your Relationship to the Subscriber: _____

Workers Comp or MVA (Name of Insurance)_____ Telephone: _____
Claim Handler's Name _____ File / Claim # _____

If you are represented by an attorney for litigation

Attorney name _____ Address _____ phone _____

CONTINUED ON BACK ➡

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent and authorization for Premier Physical Therapy Inc., to provide examination, treatments, and services by a physical therapist to myself/designee:

I realize and certify that no guarantee or assurance has been made as to the results that may be obtained for such examinations, treatments, and services.

ASSIGNMENT AND RELEASE

I hereby authorize my insurance company to pay benefits directly to Premier Physical Therapy Inc, or its designee, for services rendered and agree that I am financially responsible for non-covered services. I also authorize Premier Physical Therapy, Inc., to release any and all requested information pertaining to treatment necessary to process a claim(s) for physical therapy benefits. (Physician, Insurance company, Attorney etc)

FINANCIAL POLICY STATEMENT

It is our policy to bill your insurance carrier as a courtesy to you, although you are responsible for the entire bill when services are rendered. Questions and/or concerns about the bill and payment policies should be directed to our Billing Department, at 207-926-1107.

Evidenced by my signature below, I agree to pay any balance of the provider service charges over and above the insurance coverage. I understand that account balances remaining due 90 days and more after the date services were provided will be subject to a 1.5% finance charge per month and any cost incurred in the recovery of those charges including collection costs and reasonable attorney's fees will be my responsibility. Customized payment programs may be available on a pre-arranged basis.

I understand and authorize Premier Physical Therapy Inc., to bill my health insurance if a claim is contested, or remains unpaid after 30 days from submission, by my Worker's Compensation or Liability Coverage. Further, if my claim is covered under liability coverage (due to accidental injury and/or motor vehicle accident), I authorize my attorney and/or the responsible party to make payment in full directly to Premier Physical Therapy, Inc on my behalf. I understand that if I settle a case with Workers' Compensation or a Third Party Liability Insurer, it is my sole responsibility to ensure that my claims have been paid in full by the insurer, or that I will be responsible for paying the entire balance personally.

I understand that it is my sole responsibility to understand my insurance coverage, and that I will independently verify my physical therapy benefits with my insurer. Any balance that remains unpaid after my insurer has processed my claims, minus any contractual discount that Premier Physical Therapy, Inc is required to extend to me, is my full responsibility.

I have read the above information and understand that ultimately it is my sole responsibility for the payment of my account.

PATIENT ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS AND RESPONSIBILITIES

I, _____, have been provided access to, and have been offered a copy of, the Notice of Privacy Practices followed by Premier Physical Therapy Inc. I was also provided with a copy of the Patient Rights and Responsibilities. I have read and understand the Consent for Care and Treatment, Assignment and Release and the Financial Policy Statement as set forth above. I have had an opportunity to read all these documents and ask questions. I consent and agree to all the terms and conditions as set forth in these documents.

Signature of Patient:_____
If patient is a minor, Signed for Patient by: _____ (Relationship): _____

Today's Date: _____ Witness: _____