PINE RIVER PHYSICAL THERAPY

480 Wolverine Dr. Suite 5, Bayfield, CO 81122 (970) 884-2956

PATIENT INFORMATION

Name: Last _____ First _____ Age_____

Date of Birth _____/_____/_____ M___ F___ SS#_____

Mailing Address _____ City _____ State _____ Zip _____

Physical Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

Referring Physician _____ Phys Ph. _____

Employer _____ Employers Phone _____

Employer Address (Work Comp Only) _____

Emergency Contact _____ Phone _____

Relationship to Patient _____ (Self, Spouse, Child, etc.)

**Preferred Method of Appt Reminders: TEXT VOICE (Circle One)

Primary Insurance Company: _____

Relationship to Insured: SELF SPOUSE MOTHER FATHER GUARDIAN (Circle One)

Name of Insured _____ DOB _____

Policy / ID Number _____ Group/Plan Number _____

Phone Number _____

Secondary Insurance Company: _____

Name of Insured _____ DOB _____

Policy / ID Number _____ Group/Plan Number _____

Phone Number _____

Work Related: YES NO Auto Accident: YES NO Other: YES NO

If so, claim # _____ Date of Injury_____

Insurance Company Name _____

Claims Adjuster Name _____

Claims Adjuster Phone # _____

INFORMED CONSENT

I consent to and authorize Pine River Physical Therapy, LLC, to administer all treatments and services that may be considered advisable in the judgment of my physician and/or therapist, in accordance with established policies.

SIGNATURE OF PATIENT _____Date: _____
(or Guardian)

CONSENT FOR USE OF HEALTHCARE INFORMATION FOR PURPOSES OF PAYMENT AND HEALTHCARE OPERATIONS.

I consent to the release of, and use by, or disclosure of my protected health information to and by Pine River Physical Therapy, LLC, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct healthcare operations at this clinic.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed, to carry out treatment, payment, or healthcare operations at this clinic.

I authorize the following person(s) to have access to my protected healthcare information at any time (you do not have to authorize any additional person(s) to have access to your records)

_____ _____
Authorized Person / Relationship to patient Authorized Person / Relationship to patient

SIGNATURE OF PATIENT _____ Date: _____
(or Guardian)

FINANCIAL RESPONSIBILITY

It is your responsibility to understand the benefits and limitations of your insurance coverage. Pine River Physical Therapy, LLC maintains contracts with most of the major insurance companies. However, you may be responsible for out-of-network charges if we are not contracted with your insurance company. Pine River Physical Therapy, LLC will attempt to obtain eligibility/benefits and prior authorization for any services provided, but this will not release your responsibility for payment if your claim is denied.

By signing below, I hereby assign all medical benefits for which I am entitled to Pine River Physical Therapy, LLC. I further authorize and direct my insurance company to issue payment directly to Pine River Therapy, LLC if the provider is under contract. I agree to forward any payments received from my insurance company directly to Pine River Physical Therapy, LLC at

480 Wolverine Dr, Suite 105, Bayfield, CO. 81122

I understand that co-payments are due at time of service. Failure to pay your co-pay may result in my appointment being rescheduled. I understand that I am responsible for any amounts not covered by insurance.

SIGNATURE OF PATIENT (Or Guardian) _____

ACKNOWLEDGEMENT OF RECIEPT OF PRIVACY PRACTICES

I understand and have reviewed Pine River Physical Therapy, LLC, Notice of Privacy Practices. The Notice of Privacy Practices describes the types, uses and disclosures of my protected healthcare information that may occur during my treatment, payment of my bills by an insurance company, and in performance of the healthcare operations.

SIGNATURE OF PATIENT (Or Guardian) _____ Date _____

CANCELLATION / NO-SHOW POLICY

Cancellations and no-shows are a significant problem in our industry. As a result, we have a very limited exceptions policy in effect for cancellations and no-shows. Patients need to understand that we are not reimbursed by any insurance for missed appointments. We also have a substantial waiting list of patients needing therapy who are unable to schedule if we do not receive advance notice of cancellations. Please review the information below and ask the front desk if you have any concerns or questions.

1. Scheduling is done on a first come/first serve basis. While we will try to schedule patients with consistent times when requested, we cannot guarantee times are always available. The best way to ensure you have the times you requested is to make your scheduled appointments each week.
2. *Please* DO NOT make an appointment unless you are sure you can attend that appointment. Cancellations fees are as follows:

CANCEL LESS THAN 24 HOURS IN ADVANCE = $50.00

****PRPT reserves the right to alter this fee schedule as necessary with 30 days notice to patients****

3. Payment for cancellations or no-shows must be paid at the next scheduled appointment. Failure to pay the fee may result in your appointment being re-scheduled for a different date/time. We accept check, cash, or credit cards.
4. If you must miss an appointment, you must contact the Front Desk directly. Voicemails received after the close of business are not considered 24 your notice and do not guarantee your scheduled time will be honored.
5. We will make limited exceptions in winter for inclement weather at our discretion. More information will be posted in late fall each year. Generally, if the schools are open, we will be open, and same day cancellations will incur the standard 50.00 fee.
6. **We do not make exceptions for illness**. We may allow for limited exceptions due to certain circumstances, at our sole discretion.
7. We reserve the right to discharge patients that incur **(3)** cancellations or **(2)** no-shows during their established Plan of Care. Patients should understand that successful completion of their therapy requires active engagement in their care and that attending scheduled visits is required to continue receiving services at our clinic.

SIGNATURE OF PATIENT (Or Guardian) _____