Greene Physical Therapy

607-656-4464

Name: _____ Sex: M F Date of Birth: _____

Address: _____ Employer: _____

_____ Employer Address: _____

Email: _____ _____

Phone: _____ SSN: _____

Emergency Contact: _____ (Phone): _____

Referring Physician: _____ Primary Care Physician: _____

Fill out the following information that applies to you:

Private Insurance name and ID# _____

Worker's Compensation name and claim#: _____

_____

No Fault name and claim#: _____

_____

Have you had any surgeries, x-rays, MRI, CT-scans or any other procedures done pertaining to this incident: If so, what location(s): _____

Do you authorize Gary G Parker Jr PT, PC (Greene Physical Therapy) to obtain your records/reports from these locations: YES_____ NO_____

Do you have any allergies? If so, please list: _____

Are you currently taking medication(s): If so, please list them or give the front desk a list to copy.

Signature:_____ Date_____

Assignment of Insurance Benefits

I authorize my insurance company to make payment to Gary G Parker Physical Therapy, PC (Greene Physical Therapy) for services rendered to me or my insured dependents. _____Initials

If Medicare is filled, I authorize the release of any medical information or other information necessary to process claim. I also request payment of government benefits either to myself or to the party who accepts payment. _____Initials

I agree to notify this office of any changes in my insurance status or the information given this date. I understand that failure to provide updated information may result in denial of payment and will become my financial responsibility. _____Initials

I understand that obtaining prior authorization and verification of eligibility and benefits does not guarantee payment and that I am ultimately responsible for all out of pocket expenses, which may include, but are not limited to, co-pays, coinsurance, deductibles, non-covered services, no-show fees, and that balances are due at time of service. _____Initials

I understand that even if I have secondary insurance, I may still be responsible for balances due as dictated by primary insurance if secondary insurance does not pay (Medicaid is the exception). _____ Initials

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION REGARDING GARY G PARKER JR PHYSICAL THERAPY, PC (GREENE PHYSICAL THERAPY)'S FINANCIAL POLICY. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR ANY BALANCES DUE ON MY ACCOUNT.

Authorizing release of information: I further authorize Gary G Parker Jr, PT PC to release information for this episode of physical therapy and/or to allow review of my medical record for reimbursement purposes. I further consent and authorize the release of information from Gary G Parker Jr PT, PC to physicians or health professionals involved in my care.

Consent for care / treatment: I hereby consent to care by Gary G Parker Jr, PT PC. I acknowledge and consent to the following: I understand that my care is based on a treatment plan ordered by my physician; my treatment plan may change as my care needs change and that I will be informed of treatment plan changes.

Insurance: We will submit your insurance claims to the insurance company that holds your policy, but the insured is responsible for any co-pays, co-insurances, deductibles and any other patient responsibility charges. I understand that I will be responsible for all collection fee incurred.

Patient signature: _____ Date: _____