kitsap physical therapy

What influenced your decision to come to KPT the most?

☐ *Friend/Relative recommendation* ☐ *Social media* ☐ *Physician* ☐ *Other*_____

Have you ever had Physical Therapy before? Yes No If yes when ____/____/_____ **Male / Female (circle one)**

Today's Date_____, **Minor YES / NO Parent or Guardian**_____

Verified by:___

Patient Name_____, **Birthdate**_____
Last First MI

OFFICE USE

Int. tr._____

PT_____

Mailing Address:_____/_____
(E-mail optional)

City:_____**Zip:**_____, **Phone: (** **)**_____

Referring Dr:_____**PCP**_____ **Patients SSN:**_____
(*required for L & I, Tricare & VA*)

Employer:_____ **Work Phone:**_____

Emergency Contact _____PH #_____

Date of Onset or recurrence of injury:_____**(mm/dd/yyyy)**
All insurance companies require Month-Date-Year in order for us to bill

Cause (i.e. fell skiing, yard work, sports, etc.):_____

Body Part affected (be specific i.e. right knee, left elbow, etc.)_____

Was this a JOB related injury? YES / NO (If yes complete information below)

Claim #_____ **(USA) State in which injury occurred**_____

Was this an Auto accident? YES / NO (If yes complete information below)

Is there an at fault party or 3rd payer involved? YES / NO

Date of Accident ____/____/_____ **Location of Accident**_____
ADDRESS

At Fault Party: _____
NAME ADDRESS ZIP

Patient's (PIP) Ins._____**Ph #**_____**Adjuster**_____**Claim #**_____

Address_____**City**_____**Zip**_____

At fault party Ins. _____**Ph #**_____**Adjuster**_____**Claim #**_____

Address_____**City**_____**Zip**_____

Do you have an attorney? YES / NO

Attorney: Name_____**PH #** _____

Address_____**City/State**_____**Zipcode**_____

kitsap physical therapy
AND SPORTS CLINICS

RELEASE OF INFORMATION* PAYMENT AGREEMENT
CANCELLATIONS/NO SHOWS* ASSIGNMENT OF BENEFITS

Physician _____ Insurance _____

Release of Information:

I hereby authorize KPT to release information to: Attorney _____ Other _____

We are committed to providing the best possible care for you. Our fees fall within the acceptable range of 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 maximum benefit from your insurance, we need your assistance and your understanding of our payment policy. **Please check YES ___ or NO_ if you need to set up a payment plan prior to treatment.**

1. **PAYMENT AGREEMENT:** I understand that all therapy services are my responsibility regardless of the insurance or other third party coverage. I agree to pay my co-payment amount of _____ as required by my insurance plan or I will pay to Kitsap Physical Therapy a co-insurance amount of _____ per visit while insurance claims are pending.
We will be happy to process your insurance claims and request assignment of private benefits (see form below) unless you pay in full at time of treatment. **It** is your responsibility to understand your insurance policy and coverage. Should insurance benefits paid to us result in a credit balance, your money will be promptly refunded to you.
A monthly statement will be sent to you. Past due accounts (over 60 days) will be subject to a $10 re-billing fee.
(We accept payment by cash, check, Mastercard, Visa, Discover and American Express) We also accept debit cards with the Visa or Mastercard logo. You may also go to www.kitsappt.com and click on the bottom of the page where it says "pay bill". A $40.00 handling fee will be charged on all NSF checks returned.
In a situation of pending litigation (or dispute as to responsible party), prior written arrangements must be made for consistent payment of the account balance as we are unable to wait for resolution of a dispute. We reserve the right to discontinue treatments if reasonable, regular payments are not made, or if the balance becomes untenable.
Legal procedures for collection of past due accounts will be initiated if non-payment of account extends beyond 90 days. The undersigned will be responsible for payment of reasonable attorney fees and all collection costs, including court costs in the event action is commenced to collect on past due accounts.

2. **MEDICARE:** Effective 1/1/16 Medicare has placed a cap of $1960.00 a year on all outpatient physical therapy and speech therapy combined. Medicare will pay 80% of the allowed charges *(this is per calendar year after you have met your deductible)*. Medicare does not allow us to write off any portion of the 20% co-pay or deductible. Please make sure to let us know if you have used any of these benefits prior to your visit today. Please understand that payment in full for all charges is your responsibility.

3. **CANCELLATIONS/NO SHOWS:** If during the course of treatment, I must cancel a scheduled appointment, I will notify KPT no less than 1 business day before the time of my appointment. If I do not notify KPT within that time frame, I will be considered a no show. I realize that I must confirm any additional appointment within 24hrs of the missed appointment or KPT will cancel all future appointments. When you know you will be available to come in again, just call our office to be re-scheduled. If I no show a second time, I will be subject to a $40 fee, and KPT will no longer be able to set aside time for me on the schedule and I will be on a same day basis and worked into the schedule if time allows.

4. **CONSENT FOR SERVICES/INFORMATION:** I voluntarily consent to physical and/or occupational therapy services at KITSAP PHYSICAL THERAPY & SPORTS CLINICS as ordered by my physician, physical and/or occupational therapist. I authorize KPT to release any information it may have on my condition to my physician, insurer or attorney as indicated above.

ASSIGNMENT OF INSURANCE: I authorize payment of medical benefits to KITSAP PHYSICAL THERAPY & SPORTS CLINICS and I have read and understand the payment agreement.

SIGNATURE _____ DATE _____

GUARDIAN _____ WITNESS _____

Revised 01/20/14