Verified: _____ Date: _____ PT: _____ (OFFICE USE)

kitsap physical therapy
AND SPORTS CLINICS

How did you hear about KPT? ❑ Friend/Family ❑ Social Media ❑ Physician ❑ Ad ❑ Online Search ❑ Newsletter ❑ Community Talk

Last Name _____ **MI** ___ **First Name** _____ **DOB** ___/___/_____

Address _____ **City** _____ **State** ____ **Zip** _____

Cell (_____) _____ **Alt Phone** (_____) _____ ☐ **Male** ☐ **Female**

Permission to text appointment reminders ☐ **Y** ☐ **N** **Social Security #** _____-_____-_____

☐ **I hereby give permission for KPT to leave a detailed message on my voicemail/answering machine.**

Email address _____ **Employer:** _____

☐ **I hereby give permission for KPT to send me email messages.**

Parent Name _____ **Address** _____ **Phone** (____) _____
(If patient is a minor) ***(If different from above)***

Emergency contact _____ **Relationship** _____ **Phone** (_____) _____

Injury/Body Part(s) _____ **Date of Injury** ____/___/_____ **Cause** _____

Referring **Physician** _____ ***Primary Care*** **Physician** _____

Primary Insurance _____ **Secondary Insurance** _____

☐ **L & I Claim** ☐ **Workers' Comp/Self -Ins Claim** **Date of Injury** ___/___/____ **Claim #** _____

Employer _____

Claim Manager's Name _____ **Phone** (____) _____

☐ **Motor Vehicle Accident** **Date of Accident** ____/____/_____ **State accident occurred** _____

Your Car Insurance Company _____ **Available P.I.P.?** ☐ **Y** ☐ **N**

Adjuster's Name _____ **Phone** (_____) _____

☐ **I acknowledge receipt of a copy of the Notice of Privacy Practices.**
☐ **I have been offered a copy of the Notice of Privacy Practices, but have chosen to decline.**
☐ **I hereby give permission for KPT to discuss my medical information with** _____

Consent for Treatment, Assignment of Benefits, & Release of Information: *I authorize the use of this signature on all insurance submissions. A photocopy of this document is considered as valid as the original.*

Signature _____ **Date** _____
(Parent or Guardian, if patient is a minor)

Revised: 07/09/2021

FINANCIAL POLICY

Our Billing Department is available to discuss any questions you may have regarding your insurance or account at (360) 779-5732 during the hours of 8:00 AM to 5:00 PM Monday through Friday.

INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will bill your insurance plan for you, as long as you provide us with the correct and current information. Your contract dictates the services that are covered and the amount of payment for those services.
You are ultimately responsible for payment of services provided.

MEDICARE: An annual financial threshold is set each 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% copay or deductible. Please make sure you let us know if you have used any of these benefits prior to your visit today.

DOCTOR REFERRALS: You are responsible for obtaining the appropriate referral from your physician prior to your appointment. It is your responsibility to make sure we have a valid and current copy of your referral in the office at the time of your appointment. Exceptions to this policy are plans that have direct access to therapy (no referral required).

PAYMENT ISSUES: If financial problems arise, please contact our Billing Department. Payment plans are available, but if you or the person financially responsible does not adhere to the payment plan, the balance is due immediately. If an account becomes past due, it may be turned over to a Collection service.

NO SHOW/CANCELLATION POLICY: If you need to cancel an appointment, we require 24 hours notice as a courtesy to other patients and your therapist. Failure to give 24 hours notice or not showing for your appointment may result in a $40 fee (not payable by your insurance company). Arriving at your appointment more than 10 minutes after your scheduled time may also be considered a no show. Multiple no shows or late cancellations may result in all remaining scheduled appointments being removed and you would be placed on a "same day scheduling status", upon payment of missed appointment fees.

I understand that I am financially responsible for all charges for services rendered by Kitsap Physical Therapy and Sports Clinics. I understand that the benefits estimated are not a guarantee of claim payment.
I understand that payment is dependent on my eligibility at time of service and ALL terms and conditions of my insurance plan. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. I have carefully read the Financial Policy and by signing below I understand and agree to the terms therein.

_____ _____
Signature of Patient or Financially Responsible Party Date

_____ _____
Print Name Clinic Witness Initials