PATIENT INFORMATION

How did you choose this clinic? *Facility:*

Today's Date:

Name, Last: First: M.I. Male / Female

E-mail:

Address: Apt # City: State: Zip:

Cell Phone #: Home #: SS#:

Age: Date/Birth: Marital Status: S M D W Student Other

Emergency Contact: Name Phone:

EMPLOYMENT INFORMATION

Employer: Address:

Full Time / Part Time Work #:

MEDICAL INFORMATION

Have you had any therapy provided to you within the last year? Yes No Where:

Injured Body Part: Date of Injury/Onset of Symptoms:

Work Related: Yes No Accident: Yes No Auto: Yes No If Auto, what State:

Referring Physician Name: (Last) (First) Phone:

Primary Care Physician: Phone:

Date of Next Physicians Visit: Date of Prescription:

MEDICARE PATIENTS

Have you had any therapy of nursing services in your home? Yes No Name of Agency:

Medicare ID#

PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company:	Insurance Company:
Phone:	Phone:
Subscriber Name:	Subcriber Name:
Subscriber Date of Birth:	Subcriber Date of Birth:
Relationship to Patient:	Relationship to Patient:
Subscriber Employer:	Subcriber Employer:
ID/Claim #:	ID/Claim #:
Group #:	Group #:

ACCIDENT

Accident?: ☐ Work Related ☐ Auto ☐ Other _____

Date of Accident: State Accident occurred:

Current Occupation:

Insurance Company:

Address: Phone:

ID/Claim #: Adjuster Name: Phone:

Employer: Phone:

Address:

Rehabilitation Nurse/Case Manager Company Name:

CONSENT FOR TREATMENT

I heareby authorize and give my consent to Therapy Consultants to provide me with physical therapy services. Initial _____

FINANCIAL POLICY

Thank you for choosing Therapy Consultants as your physical therapy provider. We will work closely with you and your physician to provide you with treatment. Please understand that timely payment for your treatment is important. Your clear understanding of our financial policy is important to our professional relationship.

Cancellation/No show policy: A 24 Hour notice must be received or a fee will be assessed.

1. *All co-pays and deductibles are due at the time of service.*
2. *Payment of patient balance is due in full at the time of service unless other arrangements have been made. If you cannot make full payment at the time of service, please discuss this with our Patient Care Advocate.*
3. *If any portion of your account balance exceeds 60 days you will be responsible for this amount, plus interest here in at 1 1/2% per month, regardless of your insurance.*

We accept cash, checks, Visa, MasterCard, Discover and American Express

INSURANCE

We accept Medicare, all major insurance and numerous PPO and managed care contracts. Please be aware that some, and perhaps all, of the services provided may be considered not medically necessary by your insurance provider. You will be responsible for these charges. Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. Therapy Consultants will submit all claims for charges to your insurance provider as a service to you. Co-pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, be sure to have it with you when you come to our office. Failure to obtain and present this at the time of service may result in a loss of your insurance benefits. If you need assistance in obtaining a referral, please ask our Patient Care Advocate.

To guarantee payment for services rendered, we request documentation of a major credit card. Please provide the following information:

Credit Card Type: Master Card / Visa / Discover / American Express

Name on Card _____

Card # _____ **Exp Date:** _____

For your convenience, if you would like your credit card debited weekly for co-pay portion or total charges, please initial here: _____

Date: _____. **Select One: Co-pay Total charge**

Please be advised that if you are paying by check, Therapy Consultants charges a $35 fee for returned checks.

Thank you for understanding our financial policies. If you have any questions or concerns, our Patient Care Advocate will be happy to discuss them with you.

I authorize payment of benefits directly to Therapy Consultants for services provided.

Signature of Patient (Parent / Guardian, if necessary) ***Therapist Signature***

_____ **Date:** _____ _____

* QUOTATION OF BENEFITS IS NOT A GUARANTEE OF PAYMENT.

I hereby authorize Therapy Consultants to release any information necessary to secure the payment of benefits. I also authorize direct payment to Therapy Consultants for any payments due. I authorize the use of this signature on all my claims submissions. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I am fully responsible for any collection fees necessary to collect this account.

Patient / Responsible Party ***Patient Care Advocate / Facility Manager***

_____ **Date:** _____ _____

HANS HUMBERGER PHYSICAL THERAPY

at

THERAPY CONSULTANTS

"The Results Team"

Hans C. Humberger, PT
Nancy Humberger, PT

Jill Selby, Office Manager

INFORMATION FOR PATIENT

Welcome to Therapy Consultants!

Personal Items & Clothing:
Patients are encouraged to wear comfortable clothing when receiving therapy treatments. We have shorts and gowns, at the clinic, for your use during treatment. Appropriate attire typically includes shorts, t-shirts, and gym shoes. Tank tops or halter tops are better for neck and shoulder injuries. Please make sure that the involved body part and surrounding areas are easily exposed. A wash-room is available for clothing changes. Please secure all personal items. Therapy Consultants is not responsible for any lost or stolen items. If items need to be secured, please see the facility manager prior to treatment.

Workers' Compensation Patients:
We appreciate your full cooperation in attending all scheduled therapy sessions. We are required to inform your workers' compensation adjuster and/or rehabilitation case manager of all missed or canceled appointments. It is also required that all missed visits be rescheduled.

Billing/Payments:
All patients' co-pays are to be paid on the same day of treatment session unless other arrangements are made with the front office coordinator. All billing questions should be addressed to our front office coordinator. Please inform us immediately if you have made any changes in your address, phone number or insurance carrier. The patient is ultimately responsible for all outstanding balances.

Cancellations/No Show Appointments:
In order to treat your injury in a timely and efficient manner, you are expected to attend all scheduled therapy visits. All cancellations are to be at least 24 hours in advance, and rescheduled within the same business week whenever possible. There will be a $ 35.00 charge to all patients who cancel their appointments with less than 24 hour notice, unless that appointment is rescheduled. There will be a $ 35.00 charge to all patients who do not show up for their scheduled appointments.

Three consecutive no shows appointments may result in a discharge.

_____ _____

Patient or Guardian Signature **Date**

As a courtesy to other patients, please do not bring children and spouses into the treatment area.

Thank you for choosing Therapy Consultants as your physical therapy provider. Our highly skilled staff is looking forward to helping you accomplish your rehabilitation goals in a safe and timely manner.

2255 Center Street, #104 * Chattanooga, TN 37421 * Phone 423-855-0745 * Fax 423-855-7898
E-mail: Therapyconsultants@comcast.net

HANS HUMBERGER PHYSICAL THERAPY
at
THERAPY CONSULTANTS
"The Results Team"

Hans C. Humberger, PT
Nancy Humberger, PT

Jill Selby, Office Manager

Deductibles

According to your contract with your insurance company, we must collect ALL deductibles. With the deductible it's $100 for your first visit and $65 each time you come in. This is due while checking in or before checking out. The balance of the deductible will be billed to you; payment plans can be arranged. Thank you!

Signature :_____

Date : _____

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