

Patient Information

Patient Name _____ Birthdate _____ Age _____

Address _____ City _____ State _____ Zip _____

Physical address if using a P.O. Box _____

Home Phone _____ Work Phone _____ Cell _____

Marital status Yes/No Employer _____ Occupation _____
(If self-employed, please list company name on employer line)

In Case of Emergency Contact (required) _____ Phone _____

Whom may we thank for referring you to our office? (please list the physician and/or name of the person who referred you to Biosports)

Physician _____ Friend/Relative/Patient _____

How did you hear about Biosports? _____ Radio / Newspaper ad / Other _____

Responsible Party Information

(This is required if patient is a minor or under the parents insurance)

Responsible Party (Parent/Guardian) _____ Birthdate _____
(please list same if patient is responsible party)

Employer _____ Occupation _____ Work # _____ Cell # _____

Spouse of patient or parent/guardian _____ BirthDate _____

Employer _____ Occupation _____ Work # _____ Cell # _____

PRIVATE INSURANCE

(Co-pays and Co-insurances are due at each visit. Thank you!)

Primary Insurance Co. _____ ID# _____ Group # _____

Subscriber Name _____ Date of Birth _____

Secondary Ins. Co. _____ ID# _____ Group # _____

Subscriber Name _____ Date of Birth _____

Work Injuries or Motor Vehicle Accident Information

Date of Injury _____ Claim # _____ SS# _____

Employer where injury occurred _____ Claims Manager/Adjuster Name _____ Phone# _____

Motor Vehicle Insurance _____ Phone _____ Claim # _____

This office offers courtesy of primary insurance billing, the patient is responsible to pay balance and bill secondary insurance. The responsible party/patient is fully responsible for payment of all charges incurred. I authorize my insurance benefits to be paid directly to Biosports Physical Therapy, for services rendered. I understand I am financially responsible to pay on the day of service any deductibles and non-covered services/supplies. I authorize Biosports Physical Therapy to release any information requested by the insurance company with regards to payment of benefits. I understand that, where appropriate, credit bureau reports may be obtained. The patient/responsible party will be responsible for all costs incurred in collection of unpaid balances. These costs include but are not limited to collection fees, attorney fees, court fees, filing fees, service fees and investigation fees.

Although insurance will be verified by Biosports, patients are also expected to verify outpatient physical therapy benefits including needed referrals, visit maximums, deductible, co-pays, non covered services and policy limitations. Please notify office of any change in insurance. Biosports will help in maximizing employee benefits through insurance companies by submitting claims as a courtesy. Claims over 60 days will be resubmitted and patients are asked to be actively involved in bringing account to current status. Any unpaid claims over 90 days will be patient responsibility. Any account in an overpayment status will be researched and the appropriate party will be refunded. In case of accidents, a lien will be filed against any pending settlement. The filing fee, court fee, notary fee and any other fee associated with filing the lien will be the patient/responsible parties responsibility to pay. In the case of worker's compensation, if the claim is closed or denied for any reason, the patient/responsible party will be required to pay for all charges incurred.

We must enforce a strict policy requiring that you arrive on time for your appointment. Two failed appointments without 24 hour notification may result in your discharge from our care and/or a \$50.00 cancellation fee to be paid prior to your next appointment time. Claims manager's of worker's compensation patient's will be notified on your second failed appointment.

REQUIRED: "I am not receiving DSHS medical assistance, I agree that if I later become eligible for DSHS medical assistance, I will notify Biosports." _____ (Please initial)

Responsible party signature _____ Date _____
(Patients under the age of 18 or patient's on their parent's insurance plan need the signature of a parent.)

Please read entire document and ask any questions prior to signing.