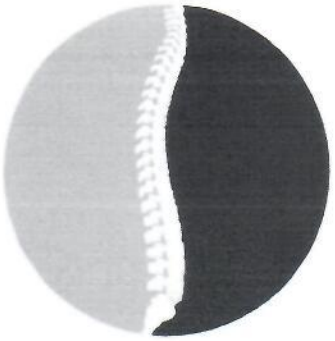

CEM

PHYSICAL THERAPY & REHABILITATION

Creating excellence in mobility

Date_____

Patient Last Name_____ Patient First Name _____

Social Security_____ Date of Birth _____ Age_____ Sex F / M

Address_____ City_____ State_____ Zip_____

Home Phone Number_____ Cell Phone Number_____

Email Address_____ Marital Status- (Circle One) Single Married Divorced Widowed

Onset of Symptoms _____ Date of Accident_____ Date of Surgery_____

Emergency Contact

Name_____ Phone_____ Relationship to Patient_____

Primary Care Physician_____Phone_____

Referring Physician Name _____ Phone_____

Employer_____

Employer Address_____Phone _____

Occupation_____ Retired Y / N

Workers Comp Related Y/ N Carrier_____Claim #_____

Primary Medical Insurance

Policy Holder Name_____ SSN_____ DOB_____

Plan Name_____ ID #_____ Policy #_____

Secondary Medical Insurance

Policy Holder Name_____ SSN_____ DOB_____

Plan Name_____ ID #_____ Policy #_____

I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I authorize the release of any medical information necessary to process and insurance claim and request that payment of benefits be made to the physician unless my account has been paid in full.

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

We will request to photocopy your insurance card(s) and photo identification card for your file.

- **APPOINTMENTS**- 24 hour notice must be provided in the event you cannot keep an appointment.
- **REFERRALS**- If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, you will be requested to sign a financial waiver. It is then your responsibility to provide us with the referral within 48 hours or you will be personally responsible for that day's services.
- **CO-PAYMENTS**- By law we must collect your carrier designated co-pay. This payment is expected at the time of the service. Please be prepared to pay the co-pay at each visit.
- **OUT OF NETWORK PLANS-** You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. If we do not participate with your plan, we will send a courtesy bill to that carrier on your behalf. Private Insurance Authorization for Assignment of Benefits. Information Release: I, the undersigned, authorize payment of medical benefits to CEM Physical Therapy & Rehabilitation for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to release to my insurance company (or their agent) information concerning health care, advice, treatment, or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.
- **SELF-PAY PATIENTS** –Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **MEDICARE**- We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one. Medicare Lifetime Signature on File: I request the payment of authorized Medicare benefits be made on my behalf to **CEM Physical Therapy & Rehabilitation** for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.
- **PERSONAL INJURIES AND ACCIDENTS:** The patient will be responsible for letter of protection. In order to treat your injury, letter of protection from your attorney, document signed by both the lawyer and the client/patient to **CEM Physical Therapy & Rehabilitation**. The letter states that the patient does not have adequate funding at the current time to cover medical service, but they are represented by counsel and are involved in a personal in a personal or any other injury case and will get paid after the accident claim is settled. I understand that if for any reason your case is not settled in your favor you will still be responsible for paying your medical bills.

You are responsible for the timely payment of your account. Should it become necessary for us to use an outside agency to collect payment from you, you will be responsible for collection charges we incur as a result of this.

Thank you for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Name Printed:_____ Date:_____

Signature_____ Relationship: _____