Physical Therapy and Sports Medicine

Layton - Mtn. Green - North Ogden

Patient Information

Name: _____ DOB: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Mailing Address (if different than above): _____ City: _____ State: ___ Zip:_____

Phone #: _____Cell#_____ SS#: _____ - ____ - _____ Gender: M / F

Marital Status: single divorced separated married widowed

Employer: _____ Phone #: _____ Full / Part Time

Email address: _____

How did you hear about us? (Please circle one)

Doctor Internet Friend _____ Phone Book(list which one) _____

Responsible Party/Guardian (if patient is a minor)

Name: _____ SS#: _____ - ___ - _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ Cell #: _____

Relationship to Patient: _____ Gender: M / F Birth Date (MM/DD/YY): _____

Employer: _____ Phone #: _____ Full / Part Time

Provider

Referring Physician: _____ Phone #: _____

Insurance Information

Primary Insurance Name: _____ Policy #: _____

Policyholder's Name: _____ DOB:_____

Relationship to Patient: _____

Secondary Insurance

Secondary Insurance Name: _____ Policy #: _____

Policyholder's Name: _____ DOB: _____

Relationship to Patient: _____

Your signature indicates receipt / acceptance of the consent and conditions of admission (see reverse).

Patient Signature: _____ Date: _____

Patient's Agent, Representative, or Parent / Guardian: _____

Relationship to Patient:

(Please, turn to the other side.)

CONSENT AND CONDITIONS OF ADMISSION

As either the patient or the legally authorized representative of the patient, the following consents, understanding and agreements are made on my own behalf or on behalf of the patient in partial consideration of the health care services to be provided to the patient in the facility.

1: Consent for Services. On behalf of the patient consent is hereby given to the facility, its contractors, medical staff, and employees provide facility and other health care services to patient and to administer physician orders for the benefit of the patient. It is understood that there is risk of substantial and serious harm involved in such facility and health care services, and such risk is accepted in the hopes of obtaining beneficial results from such services. It is understood that physical therapists are separately responsible to explain what they do and in some cases, to obtain separate consent for some of the services they perform. It is understood that now and in the future the patient and his/her legally authorized representatives have the right to ask questions and to receive answers to such questions about the patient's condition and the health care services; all such questions, if any, have been satisfactorily answered. No promise of any particular outcome or successful result have been made, it being understood and accepted that there is some uncertainty involved in facility and health care services for which this consent is given.

2: Miscellaneous agreements and understandings.

- **Medical Education.** Permission is given for observers involved in medical training and education to be present when the patient receives health care services.
- **Personal Property.** It is understood that the facility is not responsible for personal property.
- **Release of Information.** The law requires Layton Physical Therapy and Sports Medicine, INC (LPTSM) and Physical Therapy and Sports Medicine, LLC, (PTSM) to make and keep records of your medical treatments LPTSM and PTSM safeguard those records. Access to medical records is limited to persons who are providing, coordinating, evaluating, or improving health care, subject to applicable law. By receiving services at LPTSM &, PTSM facilities or from providers, you agree to the release of medical records information for the use specified above, and for release to insurance companies or other third parties to assist in paying your health care costs.
- **Assignment of Benefits.** Any and all benefits from insurance companies and other third party payers that are payable to patient on behalf of patient for health care services and related payments for services rendered or provided to patient are hereby transferred and assigned to facility for the exclusive purpose of paying for charges associated with health care services provided to patient in the facility. It is understood and intended that all insurance companies and other third party payers will pay benefits directly to facility in payment for facility charges and the charges of any other health care providers for whom facility is authorized to bill in connection with health care services provided to patient.
- **Financial Responsibility.** Patient and the undersigned, if other than the patient, each jointly and severally agree to pay for all the health care services rendered to patient in the facility including but not limited to any amounts not paid by any insurance company or a third party payer. Patient and the undersigned, if other than the patient, remains responsible for all co-pays, deductible, co-insurance, and/or non covered services regardless of amount owed by insurance or third party payer. It is understood and agreed that charges not paid in a timely fashion may be placed for collection or with an attorney for purposes of collection. Should collection become necessary, I agree to pay all attorney's fees, court costs, filling fees, and all collection costs up to 40% of the amount owing which may be assessed by any collection agency retained to pursue the matter. I further agree to pay a finance charge of 1 ½ % per month (annual percentage rate of 18% per year) of the unpaid balance. Additionally, a $10 repeat billing fee may be charged each month for continued billing for the duration of the balance. A service charge of $25.00 may be collected in connection with any check or other installment tendered by me but returned unpaid to the facility.
- **Medicare/Medicaid Patient's Certification.** I certify that the information given by me in applying for payment under titles XVIII and XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers or to the State any information needed to process a claim for this or any related service, request that payment of authorized charges be made in my behalf directly to the facility for its charges and for any charges of physical therapists or other providers for whom the facility is authorized to bill in connection with its service.

The undersigned signed this document either as the patient or as the agent representative of the patient authorized to execute this document and to accept and agree to its terms and behalf of the patient. I have read the foregoing and have had the opportunity to ask any questions I may have about the foregoing. Such questions have been answered to my satisfaction, and I understand what I am agreeing to by signing below. I understand that I am entitled to request and obtain a copy of this document.

_____

Patient/Guardian's Signature

_____

Print Name Date