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**Patient Information**

Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ M.I.\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_Zip: \_\_\_\_\_\_\_

Phone: (Home)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Cell)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Male 🞎 Female Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Single 🞎 Married Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_

Zip: \_\_\_\_\_\_\_\_\_\_ Employer Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Status: 🞎 Currently Employed 🞎 Retired 🞎 Disabled (🞎total or 🞎Temporary) 🞎student

Emergency contact: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_Zip: \_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Home 🞎 Work 🞎 Mobile

**INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS:**

I hereby instruct and direct my insurance company to pay by check made out and mailed to:

**Power Center Physical Therapy**

**PO BOX 3250**

**Victorville, CA 92395**

If my current policy prohibits direct payment to the provider, I hereby also instruct and direct my insurance company to make out the check to me and mail it to the above address for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

**This is a direct assignment of my rights and benefits under this policy.**

This payment will not exceed my indebtedness to Power Center PT, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

**I HEREBY AUTHORIZE**:

* Power Center PT to release information to insurance companies, adjusters or attorneys involved in my case, concerning my illness and treatment for the purpose of processing claims and securing payment of benefits. I have received a copy and reviewed Power Center’s Notice of Privacy Practices (NPP) and understand it provides more detailed information about how Power Center may use and disclose my protected health information (PHI).
* Power Center PT the use of this signature on all insurance submissions. A photocopy of the Assignment of Benefits shall be considered as effective and valid as the original.
* Power Center to deposit checks made in my name. (Insurance reimbursements for services rendered.)
* Power Center to initiate a complaint to the Insurance Commissioner for legitimate reasons on my behalf.

I understand that I am financially responsible for any and all charges for services rendered that may not be covered by my insurance.

**For Medicare Patients:**

Power Center Physical Therapy agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Signature of Policyholder: (If other than patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Important Company Policies**

In order to provide you with the best possible care, please adhere to the following policies: (Initial All Boxes)

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by PCPT staff. (Copayment, Coinsurance, Deductibles).

Cash or self-pay patients are eligible to receive a 30% discount off regular service fees when paid at the time of service. Please see our fee schedule for more information.

A $25.00 fee applies for all returned checks. Balances older than 30 days may be subject to additional collection fees and interest charges of 1.5% per month.

Appointments cancelled without providing 24 hours notice, will be charged a $15.00 fee. If you “*no-show*” for your scheduled appointment a $25.00 fee will be charged. No further appointments will be made until these fees are paid.

Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

Our fees fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies that pay a percentage such as 50% or 80% of "U.C.R.". "U.C.R." is defined as usual, customary, and reasonable. (This statement does not apply to companies that reimbursement based on an arbitrary "schedule" of fees, which bears no relationship to the current standard, and cost of care in this area).

I have read the **Statement of Privacy Notice**

I acknowledge that my treatment program has been explained and all of my questions have been answered to my satisfaction. I understand the risks associated with a program of Physical Therapy as outlined to me, and I wish to proceed.

I have read and agree to the Insurance Authorization / Assignment of Benefits and the Policies mentioned above.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_