HEALTH STAR PHYSICAL THERAPY, INC.

PATIENT INFORMATION: DATE:___________

PATIENT NAME_______________________________ MALE_______FEMALE_____MARITAL STATUS__________

BIRTHDATE_______________SOCIAL SECURITY #____________________HOME PHONE #_________________

ADDRESS___________________________________CITY_____________________STATE_______ZIP__________

PATIENT'S E-MAIL ADDRESS___________________@________________CELL PHONE #_________________

OCCUPATION___________________PRESENT WORK STATUS WORKING______MODIFIED/LIGHT DUTY____OFF WORK___

EMPLOYER_______________________________________WORK PHONE #_____________________________

ADDRESS___________________________________CITY_____________________STATE_______ZIP__________

EMERGENCY CONTACT NAME________________________RELATIONSHIP____________PHONE #__________

HAVE YOU *EVER* RECEIVED THERAPY FOR THE CONDITION YOU ARE HERE FOR TODAY?_____ YES _____ NO
IF YES, WHEN AND WHERE? ____
****HAVE YOU BEEN TREATED THIS YEAR OR CURRENTLY TREATING WITH A CHIROPRACTOR? ____________**

HOW DID YOU HEAR ABOUT HEALTH STAR PHYSICAL THERAPY? _____________________________________

PHYSICIAN INFORMATION:

REFERRING PHYSICIAN____PHONE #____________________

PRIMARY CARE PHYSICIAN_______________________________________PHONE #____________________

HEALTH INSURANCE INFORMATION:

PRIMARY INSURANCE_______________________________SUBSCRIBER NAME______________DOB__/__/__

RELATIONSHIP TO PATIENT______________ID#______________________GROUP#___________SEE COPY____

SECONDARY INSURANCE______________________SUBSCRIBER NAME_____________________DOB__/__/__

RELATIONSHIP TO PATIENT______________ID#______________________GROUP#___________SEE COPY____

WORKER'S COMPENSATION / AUTO ACCIDENT / PERSONAL INJURY CLAIMS:

DATE OF ACCIDENT/INJURY_______________WHERE DID INJURY OCCUR? WORK______AUTO____OTHER____

INSURANCE COMPANY NAME_______________________________________PHONE #____________________

ADDRESS___________________________________CITY_____________________STATE_______ZIP__________

CLAIM#_________________________ADJUSTER______________________PHONE #____________________

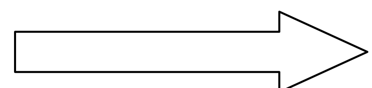
IS A REHABILITATION NURSE ASSIGNED TO YOUR CASE?________IF YES, NAME__________________________

COMPANY____PHONE #____________________

DO YOU HAVE AN ATTORNEY?_____IF YES, NAME____

ADDRESS___________________________________CITY_____________________STATE_______ZIP__________

PHONE #________________________



HEALTH INSURANCE AND FINANCIAL RESPONSIBILITY

HEALTH STAR PHYSICAL THERAPY IS A PARTICIPATING PROVIDER FOR MOST INSURANCE PROGRAMS. WE ACCEPT THEIR REIMBURSEMENT AS PAYMENT IN FULL FOR ALL COVERED SERVICES, EXCEPT FOR ANY CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLES WHICH YOU MAY BE REQUIRED TO PAY UNDER YOUR CONTRACT WITH YOUR INSURANCE COMPANY. YOU WILL BE RESPONSIBLE FOR ALL (IF ANY) UNCOVERED SERVICES.

A. ASSIGNMENT OF MEDICARE, MEDIGAP AND BLUE SHIELD BENEFITS:

I ASSIGN ANY MEDICARE, MEDIGAP OR BLUE SHIELD BENEFITS TO WHICH I MAY BE ENTITLED TO HEALTH STAR PHYSICAL THERAPY, INC.

ASSIGNMENT OF BENEFITS TO OTHER HEALTH INSURANCE CARRIERS:

I AUTHORIZE MY HEALTH INSURANCE CARRIER TO MAKE PAYMENTS OF ANY BENEFITS TO WHICH I MAY BE ENTITLED FOR HEALTH CARE SERVICES OR SUPPLIES DIRECTLY TO HEALTH STAR PHYSICAL THERAPY, INC.

B. FINANCIAL RESPONSIBILITY:

I AGREE TO PAY FOR ALL SERVICES PROVIDED TO ME TO THE EXTENT THAT SUCH SERVICES ARE NOT FULLY REIMBURSED BY MY HEALTH INSURANCE PROGRAM. I AM AWARE THAT ALL CO-PAYMENTS OR COST SHARES ARE PAYABLE AT EACH VISIT.

MEDICARE PATIENTS:

THERE IS A $1880.00 CAPITATION PER YEAR FOR PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY COMBINED. IF YOU HAVE RECEIVED ANY THERAPY WITHIN THE CURRENT YEAR, PLEASE STATE BELOW:

____

(WHEN) (WHERE)

ALSO, IT IS ULTIMATELY THE PATIENTS RESPONSIBILITY TO TRACK MEDICARE REIMBURSEMENTS, WE WILL ONLY BE ABLE TO TRACK THE PAYMENTS FOR SERVICES RENDERED AT OUR FACILITY. IF YOU EXCEED THE MAXIMUM OF $1870.00 PER YEAR WE DO RETAIN THE RIGHT TO BILL YOU DIRECTLY.

HIGHMARK AND HEALTH AMERICA/HEALTHASSURANCE PATIENTS:

PLEASE NOTIFY US IF YOU HAVE RECEIVED PHYSICAL THERAPY, OCCUPATIONAL THERAPY, OR CHIROPRACTIC CARE FOR ANY REASON DURING THIS CURRENT YEAR.

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(WHERE) (DATE) (REASON)

C. RELEASE OF MEDICAL RECORDS:

I AUTHORIZE HEALTH STAR PHYSICAL THERAPY TO RELEASE RECORDS OF MY EVALUATION AND TREATMENT AND TO DISCLOSE ANY CONFIDENTIAL INFORMATION CONTAINED THEREIN TO ANY HEALTH INSURANCE CARRIER FOR THE PURPOSE OF OBTAINING PAYMENT OR REIMBURSEMENT FOR THE PHYSICAL THERAPY SERVICES OR SUPPLIES THAT I HAVE RECEIVED.

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SIGNATURE OF PATIENT/RELATIVE/GUARDIAN