



PATIENT HISTORY

Patient's Name _____ Date of Birth _____
(last) (first) (middle)

Mailing Address _____
(number and street) (city) (state) (zip)

Home # (____) _____ Cellular # (____) _____ Work # (____) _____

Social Security # _____ Employer _____

Email address _____

In Case of Emergency Contact _____ Phone # (____) _____

Referring Physician _____ Date of Injury _____

Would you like us to provide appointment reminders? Y/N Can we leave a message regarding
appointment times on your home phone? Y/N work phone Y/N cell phone Y/N

► **INSURANCE – do not fill out if presenting card** ◀

Primary Insurance Name and Address _____

Subscriber's Name _____ Group # _____ ID # _____

Secondary Insurance Name and Address _____

Subscriber's Name _____ Group # _____ ID # _____

► Workers Compensation Carrier ◀ _____ Date of Injury _____

Address _____ Claim # _____

► **IF PATIENT IS UNDER THE AGE OF 18** ◀

Mother's Name _____ Employer _____

Work # (____) _____ Social Security # _____

Father's Name _____ Employer _____

Work # (____) _____ Social Security # _____

For patients under 18 years of age, the parent, relative, or person *escorting* the patient is responsible for any payments due at the time of the service.

- I understand that I am responsible for all charges incurred regardless of insurance or third party liability.
- I authorize contact by the use of my mobile/cell phone number for discussing treatment, confirming appointments and resolution of the balance of my account.
- I authorize Sapphire Physical Therapy to release any medical information necessary to process my claim to my insurance company or to any other concerned third party.
- I authorize my insurance company or any other concerned third party to make payment directly to Sapphire Physical Therapy.

Signature

Date



ACCOUNT AGREEMENT

- *Your healthcare coverage is an agreement between you and your healthcare payor. We ask that you understand that our services are rendered to a person rather than an insurance company. Hence, the insurance company is responsible to the patient and the patient is responsible to us. As a courtesy, we are pleased to bill your insurance company on your behalf.*

Please select the option you prefer and sign at the bottom of the page.

- I will make co-payments at the time of service.
 I want to discuss a payment arrangement for my account.
 Work related accident My workers compensation carrier authorized physical therapy.
 VA The VA authorized physical therapy.

PATIENTS WITH LIABILITY, MOTOR VEHICLE OR NO INSURANCE ACCOUNT AGREEMENT

It is your responsibility to keep in contact with your attorney, motor vehicle insurance, or other third party company. It is always your option to have your claims submitted to your health insurance. If you do not understand the options below or have any questions about our policy, please ask for our business manager.

- I will make full payments at the time of service.
 I want to discuss a payment arrangement for my account.

CREDIT POLICIES: Sapphire Physical Therapy retains the right to transfer unpaid balances to collections upon failure to make full co-payment within 60 days from the date of the "Patient Statement". If an account is placed with a 3rd party agency for collections, the patient will bear the cost for collection agency fees. I authorize contact by the use of my mobile/cell phone number for resolution of the balance of my account by either Sapphire Physical Therapy or a 3rd party agency for collections. Finance charges of no less than 15% APR will apply to unpaid balances when regular monthly payments per the above "Account Agreement" are not maintained (more than two payments missed in any six-month period) without prior agreement.

I authorize treatment and understand that I am financially responsible for all fees and charges of such treatment regardless of insurance or 3rd party liability. All proceeds of insurance are assigned to this office. I authorize Sapphire Physical Therapy to release to my insurance company and/or other concerned 3rd party, the necessary information to process claims. The above information is for the purpose of extending credit and is warranted to be true.

I have read the above Sapphire Physical Therapy billing policy agreement and agree to the terms contained therein.

Patient Name (please print)

Signature

Date



CANCELLATION & MISSED APPOINTMENT POLICY

We strongly recommend that you to attend all scheduled appointments. Compliance to your Plan of Care is essential for a safe and effective rehabilitation program. Excellent compliance often minimizes the overall amount of physical therapy needed resulting in fewer appointments, lower out-of-pocket cost to you, and a faster and safer return to your prior functional status.

Occasional soreness while progressing during the course of PT treatments is normal and should not be considered an appropriate reason to miss appointments. Many physical therapy techniques are designed to reduce pain related to treatment and healing.

We often have a waiting list to get in, therefore missed appointments or late notice cancellations may result in a missed opportunity for another patient to obtain treatment. We recognize that circumstances sometimes necessitate cancelling your appointment. Early communication is very important as it allows other patients the opportunity to get the care that they need.

Out of consideration to all of our patients, **patients with three consecutive missed appointments or cancellations with less than 24 hour notice within a two week period will be on a same-day appointment status. Those patients should call in the morning to check if we have an open appointment time for that day.**

I have read the above cancellation and missed appointment policy and I understand the importance of compliance with my physical therapy Plan of Care.

Patient Name (please print)

Signature

Date



RELEASE OF INFORMATION

Sapphire Physical Therapy
2207 S. 3rd Street W.
Missoula, MT 59808
(406) 549-5283
(406) 549-5392 fax

Date _____

Patient Name _____

Date of Birth _____

Thank you for referring your patient to Sapphire Physical Therapy.

Please forward the medical records regarding this patient so we may provide proper treatment to your patient.

I authorize the release of my (or my dependent's) medical records to Sapphire Physical Therapy.

Signature

Date



NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient, and our common practices in dealing with patient health information.

Uses and Disclosure of Health Information:

We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students.

Uses and Disclosures Based on Your Authorization:

Except as stated in more detail in the Notice of Privacy Practice, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring your Authorization:

In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care
- For certain limited research purposes
- For purpose of health and safety
- To Government agencies for purposes of their audits, investigations, and oversight activities
- To Government authorities to prevent child abuse and domestic violence
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders
- When required by court orders, search warrants, subpoenas, and as otherwise required by law

Patient Rights:

As our patient, you have the following rights:

- To have access to and/or copies of your health information
- To receive an account or certain disclosures we have made of your health information
- To request restrictions as to how your health information is used or disclosed
- To request that we communicate with you in confidence.
- To request that we amend your health information
- To receive notice of our privacy practices

Please contact us with any questions, concerns, or complaints regarding our privacy practices.

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understand the Notice.

Patient Name (please print)

Parent or Authorized Representative (if applicable)

Signature

Date