Patient Registration Form

Name Last ________________________________First _________________________MI_____

DOB _________________________ M___F___ **Email**_________________________________

Drivers License #_______________________________SS________________________________

Address____

Phone #_______________________________ Mobile #__________________________________

Emergency Contact Name, Relationship and Phone #_________________________________

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Employer ____

Phone #___________________________ Address______________________________________

Insurance Primary _______________________________Group #_________________________

ID #___________________________________ Copay amount___________________________

Insurance Secondary______________________________ Group #________________________

ID # ____ Copay amount ___________________

Workers Comp Ins. ___________________________**Case #** ___________________________

No Fault Ins. __________________________________**Case #** ___________________________

Carrier Address ____

Case Manager Name / #____

Primary Care Provider ____

Referring Provider/Person____

Financial Policies and Responsibilities

Bertolozzi Physical Therapy is committed to providing you with the highest level of care possible. It is our goal to see you through your course of treatment and allow you to focus on your recovery. We are aware that healthcare insurance plans continuously change and have become more complicated to understand. Therefore, we will help you with questions you may have regarding your financial responsibilities and concerns regarding reimbursement. As a courtesy, we will verify insurance coverage and benefits for you. We have developed these policies to help you understand your responsibility of your healthcare benefits and to avoid any unnecessary confusion.

Current Insurance and Personal Information It is important that you inform us of any changes to your insurance plan and carrier information as well as any changes to your address and or phone number. If you are issued a new card, please provide us a copy or we can do it for you.

Insurance Coverage Bertolozzi Physical Therapy and our therapists participate in many regional healthcare plans and will [in most cases] be able to bill your insurance carrier directly for services provided. It is the patient's responsibility for payment of all charges remaining not covered by the insurance company's benefit. This also includes all charges if the insurance carrier denies the claim or deems that the treatment provided is not medically necessary. Please note that our verification of benefits is not a guarantee for payment and it is the patient's or legal guardian's responsibility to communicate with their carrier regarding their coverage and benefits which includes deductibles and co-payments or co-insurance.

Deductibles and Copayments Your insurance coverage will most likely include a deductible, a copayment or both. It is part of your contractual agreement with your insurance company and, as participating providers; it is our responsibility to collect those fees. **Co-pays are due at the time of each visit** and are subject to a fee of 15% per month if we must bill you for any remaining balance. In the event that your insurance company reimburses more than the billed amount or more than your responsibility resulting in an overpayment, we will immediately reimburse you as per your insurance carrier's contract.

Payment Authorization (please initial) I authorize release of information requested by my insurance plan to expedite payment to Bertolozzi PT____. I understand that I am completely responsible for any balance due_____. I agree to comply with the terms as outlined in the financial policy____. **Print Name**____

Signature____**Date**__________