# SPORTSMED PHYSICAL THERAPY

## Patient Information

Patients Full Name:_____ Sex:_____
Address:_____City:_____State:_____Zip_____
Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____
Date of Birth:_____ Social Security Number:_____
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School_____ City/State_____ ☐ FT ☐ PT
Employer_____ Work Phone_____ Spouse or Parent's Name: _____
Person to contact in case of emergency_____ Phone_____

## Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:_____ Relationship to Patient: _____
Address:_____
City:_____ State:_____ Zip:_____ Phone: (____)_____
Employer_____ Work Phone (____)_____ SSN#_____

## Insurance Information

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Insurance Company_____ Group #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Insurance Company_____ Group #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

I hereby assign all physical therapy benefits, to which I am entitled, Medicare, private insurance and other health plans to: Sportsmed Physical Therapy, 1551 South Renaissance Towne Drive, Suite 420, Bountiful, UT 84010. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment, via Fax transmittal or hard copy.

STATEMENT OF FINANCIAL RESPONSIBILITY

The patient/responsible party is responsible for all medical bills that result from services rendered by Sportsmed Physical Therapy, Inc.

Please remember that insurance is considered a method or reimbursing the patient for fees paid to the therapists and is not a substitute for payment. Some companies may pay fixed allowances for certain procedures, sometimes referring to theses as "Reasonable and customary fees." We do not accept this as payment in full, unless otherwise restricted by law or contract agreement we may have with your insurance carrier. Many insurance companies pay only a percentage of the charge, leaving it your responsibility to pay any deductible amount, co-insurance amount and any other balance not covered by your insurance. Patient portion should be paid at the time of service.

INJURIES AT WORK: In the event it is determined by Workman's Compensation board, that the illness is not a result of a compensated Workmans' Compensation case, you will be responsible to pay usual and customary fees for services rendered.

Auto insurance claims will be billed to auto carrier, if auto has been exhausted; we require primary insurance information at time of service.

Patients without insurance will be required to pay at time of service.

Interest of 1.5% per month (18% per year) will be applied to any amount not paid after 30 days with a minimum charge of 50 cents per month.

X _____
Signature of Responsible Party

X _____
Date