Bellefontaine Physical Therapy, LTD.
Demographic Information

Patient's full Name: ____
Last *First* *MI*

Address: ____

Phone Number: (__)____________ Cell: (___)__________ Email: ______________

Social Security #: ______________ Date of Birth: __________ Marital Status: S M D W

Employer: ____

Address: ______________________________ Phone #:(___)____________

Emergency Contact: ______________________________ Phone #: (____)__________

Relationship to Patient: ______________________________

Guarantor Information: (this section should be completed if the responsible party *is not* the patient.)

Name: ____

Address (if different than the patient): ______________________________

Phone: (____)____________Social Security #: ________________ Date of Birth: ____________

Are you currently receiving Home Health Care: Y N If yes, which agency?________________

Primary Insurance:

Name of Insurance Company: ______________________________

Group #: ________________I.D./Policy #: ______________________________

Claim Address: ______________________________

Name of Policy Holder: ______________________Relationship to Patient: ____________

Address: (if different than the patient) ______________________________

Social Security #: ________________Date of Birth: ____________Phone #:(___)____________

Employer/Address: ______________________________

Secondary Insurance:

Name of Insurance Company: ______________________________

Group #: ______________________I.D./Policy #: ______________________________

Claim Address: ______________________________

Name of Policy Holder: ______________________Relationship to Patient: ____________

Address: (if different than the patient) ______________________________

Social Security #: ________________Date of Birth: ____________Phone #: (____)____________

Employer/Address: ______________________________

Tertiary Insurance:

Name of Insurance Company: ______________________________

Group #: ______________________I.D./Policy #: ______________________________

Claim Address: ______________________________

Name of Policy Holder: ______________________Relationship to Patient: ____________

Address: (if different than the patient) ______________________________

Social Security #: ________________Date of Birth: ____________Phone #:(___)____________

Employer/Address: ______________________________

Worker's Compensation:(please complete this section to the best of your knowledge.)

Date of Injury: ______________________Claim #: ______________________

Place of Employment at time of Injury: ______________________________

Case Manager: ______________________Phone #: (____)______________________

BPT Patient Information

Motor Vehicle Accident (please complete this section if your injury is result of a motor vehicle accident, even if you are billing your health insurance.)

Date of Motor Vehicle Accident: ________________ Claim #: ______________________

Insurance Company to be billed: ____

Address: ____________________________________ Phone #: ____________________

Attorney's Name: ____________________________ Phone #: ____________________

I request that payment of authorized medical or other insurance company benefits be made to Bellefontaine Physical Therapy, Ltd. (BPT) for any services furnished to me by BPT. I also authorize BPT to release medical information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made directly to BPT and authorized the releasing of information to the insurer or agency shown. In the Medicare assigned cases, BPT agrees to accept the charge determination of Medicare as full charge and the patient is responsible only for deductible, coinsurance, and non-covered services. I also understand that my signature on this form gives my permission for treatment.

We are committed to providing you with the best possible care. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. We bill Medicare direct and for your convenience we bill most commercial insurance companies. In order for us to bill your insurance for you, it is important that we have the most accurate information you can provide. We must emphasize that as medical care providers, our relationship is with you, not your insurance company. Please keep in mind your insurance is a contract between you, your employer, and the insurance company. And not all services are a covered benefit in all contracts. Though the filing of insurance claims is a courtesy that we extend to our clients, all charges are your responsibility to pay in the event your insurance does not pay. Payment is due at the time of service unless payment arrangements have been made with manager or billing personnel. We accept cash, checks, MasterCard, Visa, Discover.

I have read and understand the financial policy above. I agree to give the pertinent information in order for BPT to file the claims with my insurance company. I understand that in the event my insurance company does not pay for services, I am responsible to pay the balance on my account.

Signature: ____ Date: ________________
Patient/Parent/Guarantor

Notice of HIPPA Privacy Practices

I, ________________, acknowledge that I have received Bellefontaine Physical Therapy's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of this Notice.

Signature: ____ Date: ________________
Patient/Parent/Guarantor