MEDICARE PATIENT & PAYOR INFORMATION FORM

***All* Patients or Patients' Legal Representative, please complete all Sections**

(1) Patient: (Full Legal Name or as on Insurance Card)

Name: Last First Initial **Date of Birth** _____/_____/_____

Emergency Contact Name _____ Number(_____) _____-_____

(2) Patient's Doctor: Please list the Doctor who referred you to therapy below.

Referring Dr's Name: Last First Initial MD, DO, DDS, Other **Office Phone:** (___) ____-_____

Address: Street City,State Zip Code

(3) Condition to be treated in Physical Therapy: _____

Are You Currently Receiving Home Health? (i.e. any healthcare worker, aide assisting or doing something to or for you?) No Yes If Yes From Who?_____

Do You Live in a Nursing Home? No Yes If Yes What Is Its Name? _____

Are You Covered:

a. Under Black Lung Disease? No Yes
b. End Stage Renal Disease? No Yes
c. Large Group Insurance? No Yes If Yes Name/Group #_____
d. Veterans Affairs No Yes

(4) Payor Information Secondary/Supplemental Insurance Company: (If YES, please complete)

Ins. Co. Name: _____ **Insured's Name:** _____ **Ins. Ph#**_____

Insured is: _____**Patient** _____**Spouse** _____**Parent**

Patient ID #: _____**Group. #** _____ **Policy/Plan #:** _____

Claims Mailing Address:_____

Street City State Zip Code

Employer Name: _____ **Employer Phone # (** **)** _____-_____

Address: _____

Street City State Zip Code

All Patients or Patients' Legal Representative Please Sign Section 7 on Page 2

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(5) Payment Authorization: ***(Initials required for all 3 statements)***

_____ **Assignment of Insurance Benefits**

Initials **I authorize that the payment of my insurance benefits be made directly to Madden Physical Therapy for any services that are reimbursable by Medicare or my any other insurance company, if I have one.**

_____ **Guarantee of Payment**

Initials **I understand that all payments designated as 'the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by the billing statement due date.**

_____ **Certification of Information**

Initials **I certify that the information I have provided Madden Physical Therapy for payment under the Social Security Act (Medicare) including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.**

(6) Attendance Policy:

ATTENTION!

In order to provide our patients with the best possible care, we maintain scheduled appointments. *If you cannot make a scheduled appointment, PLEASE contact us 24 hours before your scheduled time.* This will allow us to adjust our schedule appropriately.

_____ ATTENDANCE POLICY

Initials

Individuals who attend 100% of their scheduled appointments will receive a free MADDEN PHYSICAL THERAPY gift. ***PATIENTS WHO CANCEL 3 TIMES OR NO-SHOW 2 TIMES WILL BE DISCHARGED.***

(7) Signature/ Date:

_____ _____

Patient or Legal Representative's Signature **Today's Date**

All Patients or Patients' Legal Representative Please Sign Section 7 on Page 2