

Crunk Physical Therapy, PC
105A Regency Commons Drive, Greer, SC 29650
PH: 864-373-9520 / Fax: 864-373-9522

Patient Information

Name: _____
Last First MI

Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____ Age: _____
Sex: Male/ Female Marital status: Married / Divorce / Single / Widowed / Single

Birth-date: _____ SSN: _____ E-Mail: _____

Employer Name: _____ Occupation: _____

How did you hear about Crunk Physical Therapy, PC?

Brief Description of Injury or Surgery:

Primary Care Physician: _____ Phone: _____
Referring Physician: _____ Phone: _____

Responsible Party (if different than patient) **or Parent** information:

Name: _____ Relationship to pt: _____ Birth-date: _____
First Last

Address: _____ SSN: _____
Street City State Zip

Emergency Contact: _____ Phone: _____

Primary Insurance Name: _____ **Secondary Insurance Name:** _____

Insurance Address: _____ Insurance Address: _____

Authorization Phone #: _____ Authorization Phone #: _____

Insured DOB: _____ Insured DOB: _____

Insured's ID #: _____ Insured's ID #: _____

Group #: _____ Group #: _____

Is Your Injury Related to a Work or Auto Accident? Yes/ No
Are you submitting any claims to WC or PIP? Yes/No

I, _____ certify that the above information is correct and true to the best of my knowledge.

► Signature of Patient or Responsible Party

Date

Crunk Physical Therapy, PC
105 A Regency Commons Drive
Greer, SC 29650

Financial Policies and Agreement

We would like to take a moment to welcome you to our office and assure you that you will receive the very best care available for your condition. In order to familiarize you with the financial policies of this office, we would like to explain how your medical bills will be handled.

Explanation of insurance Coverage

Most insurance policies cover Physical Therapy, but this office makes no representation that yours does. We will do our very best to verify your insurance coverage, and will bill your insurance company (ies) in a timely manner. Insurance policies can differ greatly in terms of deductibles and percentage of coverage for Physical Therapy. Because of the variance from one insurance policy to another, we require that you, the patient, be personally responsible for the payments of your deductibles, as well as any unpaid balances in this office. If your insurance company fails to process your claim within 45 days from the date of service, the balance becomes your responsibility. If an insurance problem occurs, you will be asked to assist us in contacting your insurance carrier.

As required by your insurance carrier, you are responsible for obtaining any necessary referral if your insurance policy mandates such paperwork. You will need to present a completed referral at the time of your appointment. As required by insurance mandates, you are also responsible to obtain the appropriate authorizations for medical treatments.

In the event that you are seen (by your acknowledgement) without the proper referral/ authorizations as required by your insurance carrier, you will be responsible for payment of all fees at the time of service. We will file a claim with your insurance carrier and reimburse you if they issue payment to us. We ask that you participate in any dispute with your insurance carrier regarding your policy guidelines and regulations.

Returned checks and balances referred to outside collection agencies are subject to additional fees. In addition, patients whose accounts have been referred to collection agencies must pay any outstanding balance and pay for each visit in full at the time of the appointment before additional services / care will be provided.

Our staff is available to answer questions relating to how your claim was filed and any additional information the carrier may need to process your claim. However, coverage issues are best addressed by your employer or group plan administrator. **Your insurance policy is a contract between you and your insurance carrier.** Crunk Physical Therapy, PC is not a party to that contract and cannot act as a mediator with your carrier or your employer.

Payment Arrangements

We require you to make payment at time of service. Prompt payment allows us to control costs, which ultimately keeps our fees to a minimum. Patients with a standard co-payment (i.e. \$15.00, \$25.00, etc. per visit) should render that payment at the time of service. Patients whose co-insurance is based upon a percentage of the charge should pay that percentage of the bill at the time of service. Please understand that this is an approximation and all payments will be applied to your final balance. If you have a deductible that has not been met, your insurance carrier will apply services to that deductible. We require you to pay your deductible at the time of service.

Assignment of Benefits

Attached is an "Assignment of Benefits" form which we would like you to sign. This form instructs your insurance company to send their payments directly to this office. If your insurance carrier sends you payment for services incurred in this office, it is required that you send or bring the full payment to our office immediately upon receipt.

Release of Information

If your insurance company requires medical reports to document your treatment and progress, your signature below authorizes the release of medical information necessary to process your claim.

Voluntary Termination of Care

If you suspend or terminate your care at any time, your portion of all charges for professional services will be immediately due and payable to this office. All services rendered by this office are charges directly to you, and you ultimately will be personally responsible for payment, regardless of your insurance coverage.

Explanation of Financial Responsibility Without Insurance Coverage.

I understand and agree that if I am seen (by my acknowledgement) by Crunk Physical Therapy, PC **without** health insurance coverage, I am ultimately responsible for the balance on my account for any professional services rendered. We also require you to make full payment at time of service.

Commitment to Make Co-Payment / Co-Insurance

In order to comply with your Health Insurance Company's rules and regulations, you must pay your contracted Co-Pay / Co-Insurance amount at the time of service rendered. For your convenience, Crunk Physical Therapy accepts cash, checks, and money orders.

Unfortunately, failure to pay your co-pay at time of service may result in the cancellation of your appointment. If you are seen by your physical therapist and do not pay your co-pay, a \$5.00 service fee may be added to your bill.

To avoid the service fee for not paying your co-pay at the time of service, please make the payment within five (5) business days to:

Crunk Physical Therapy, PC
105 A Regency Commons Drive
Greer, SC 29650

If necessary, for your convenience, the receptionist will provide you with a stamped envelope addressed to the practice. Simply use it to return your payment.

We hope that this answers any questions you might have concerning the financial policies of this office. Once again, we welcome you to our office and will be glad to answer any further questions you might have.

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Acknowledgement of Receipt of Notice and Privacy Practices

In general, any information regarding your health, the health care you receive, or payment for that care is considered confidential and protected by Crunk Physical Therapy, PC. We may need to and are permitted by law to use your protected health information to carry out your treatment, collections, and healthcare operations. I have been presented with a copy of Crunk Physical Therapy, PC **Notice of Privacy Practices**, detailing how my information may be used and disclosed as permitted under Federal and State law. By signing below, I acknowledge that I have been offered a copy of the Notice of Privacy Practices.

Consent to Treatment

I, a patient of **Crunk Physical Therapy, PC** consent to treatment by Timothy J. Crunk, PT, MS, OCS, CFMT, FAAOMPT and their designees, assistants, and staff. I recognize that I have a condition requiring medical care and further acknowledge that I am aware and affirm that no guarantees have been made to me concerning treatment by Crunk Physical Therapy, PC.

To Our Patients Regarding Cancellations and No-Shows

The following are our policies regarding cancellation and no-shows. We take this subject seriously. Usually your referring Doctor and/ or your Therapist have prescribed a set frequency of treatment. Attendance for these scheduled visits is your most important responsibility.

- **We require 24 hours notice in the event of a cancellation.** It is your responsibility, when you contact us, to have an alternate time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible. (In some cases, this may not work since some forms of treatment do not work well if given two sequential days.)
- **There is a \$50.00 charge for a cancellation without proper notice.** This charge will not be covered by insurance, but will have to be paid by you personally.

Assignment and Instruction for Direct Payment to Health Care Provider

Patient: _____ Date of Birth: _____

Policy Holder: _____ Date of Birth: _____

Insurance Company: _____

Claim or Group #: _____ SSN or ID # _____

I hereby instruct the above named Insurance Company to pay by check made out to and mailed directly to:

Crunk Physical Therapy, PC
105 A Regency Commons Drive
Greer, SC 29650

For professional or medical expenses allowable or otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **This is a Direct Assignment of my Rights and Benefits Under this Policy.** This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

A photocopy of this assignment shall be considered effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance.

▶ Signature of Patient or Responsible Party

▶ Signature of Policy Holder

Witness

▶ Signature of Claimant, if other than Policyholder

Date

CRUNK PHYSICAL THERAPY

NOTICE OF PRIVACY POLICIES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

CRUNK PHYSICAL THERAPY'S LEGAL DUTY

Crunk Physical Therapy, PC is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Crunk Physical Therapy, PC uses your personal health information primarily for treatment, obtaining payment for treatment; conducting internal administrative activities, and evaluating the quality of care that we provide. For example, Crunk Physical Therapy, PC may use your personal health information to contact you to provide appointment reminders, or information about treatment alternative or other health related benefits that could be of interest to you.

Crunk Physical Therapy, PC may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Crunk Physical Therapy, PC's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Crunk Physical Therapy, PC may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Crunk Physical Therapy, PC will consider all such request on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Crunk Physical Therapy, PC may have violated your privacy right or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Crunk Physical Therapy, PC's health information practices or if you have a complaint, please contact the following person:

CRUNK PHYSICAL THERAPY, PC
Office Administrator
105 A Regency Commons Drive
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