Vail Sports Medicine Physical Therapy, P.C.
Patient Information

*Please read, **PRINT NEATLY**, fill out completely, and sign.*

Name _____ Date of Birth (month/day/year) _____

Social Security # **(required)** _____

Mailing/Billing Address _____

City _____ State _____ Zip Code _____

Phone # _____ Cell Phone # _____

Your Employer _____ Phone # _____

Your Employer's Address _____

Nearest Relative not living with you _____ Relationship _____

Their Address _____ Phone # _____

Name of Referring Physician or Friend _____

What was the exact date of Accident/Onset of Symptoms? _____

Circle One (if applicable): Work Comp. Auto Accident Medicare Private/Group Ins. Self-pay

***Work Comp. and Auto Claims must have a prescription for physical therapy.**

Insurance Co. _____ Ins. Co.'s Phone # _____

Address for Claims _____

Name of Policy Holder _____ Policy/Group/Claim # _____

Policy Holder's SS# **(required)** _____ Policy Holder's Date of Birth _____

Relationship of Policyholder to you: _____

FINANCIAL POLICY

We require a social security number for all patients seen in our offices. If you do not wish to provide this, you will have to pay your bill at the time of service. Payment for treatment is due at the time of service, unless payment arrangements have been approved by our Patients' Accounts Office. We emphasize that, as health care providers, our relationship is with you, not your insurance company. We will bill your insurance company providing you give us a legible copy of your insurance card (both sides) at your first appointment. We do not take responsibility for any denial of claims by your insurance company; including denials due to lack of pre-authorization, or because of delays in receiving your health insurance information.

GUARANTEE OF PAYMENT

I hereby guarantee payment of physical therapy expenses for the above-mentioned patient while at Vail Sports Medicine Physical Therapy P.C.. I understand that payment is required at the time of service unless other arrangements have been agreed upon.

I understand that I am financially responsible to Vail Sports Medicine Physical Therapy P.C. for all charges incurred, including those not covered or paid for by my insurance carrier. I also understand that I am financially responsible to Vail Sports Medicine Physical Therapy P.C. if a problem develops with my insurance carrier and payment is not made within 30 days.

Should this account become delinquent, I understand that I will be responsible for any and all collection/attorney/filing fees.

I verify that the above information is accurate and up to date. I have read and agree to the statements above and I am seeking treatment voluntarily. My signature authorizes payment of any insurance benefits to the supplier of services (I assign any benefits directly to Vail Sports Medicine Physical Therapy, P.C.).

Signed _____ Date _____