Patient Information

A-TEAM PHYSICAL THERAPY

First Name _____ Last Name_____ SSN: _____

Address _____ Apt. # _____ City _____ State _____ Zip _____

Home Phone: _____ Cell: _____ Email: _____

Sex: [ ] M [ ] F Birth date: _____ Age: _____ [ ] single [ ] married [ ] widowed [ ] divorced [ ] separated

Who can we thank for referring you to A-Team Physical Therapy? (MD office/former patient) _____

Referring MD: _____Telephone #_____

Is your injury due to an accident? [ ] yes [ ] no if yes, [ ] work [ ] auto [ ] other - Date and State of Accident: _____

Attorney Name: _____ Attorney Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Primary insurance

Insurance Co. _____ Policy/ID # _____

Policy holder name _____

Policy holder DOB _____ policy holder SSN# _____ relation to patient _____

Policy holder address _____

Employer _____ Phone# _____

Secondary/supplemental Insurance

Insurance Co. _____ Policy/ID # _____

Policy holder name _____

Policy holder DOB _____ policy holder SSN# _____ relation to patient _____

Policy holder address _____

Employer _____ Phone# _____

Guarantor Information: (person accepting responsibility for the payment of another's debt in the event of default)

Name _____ Address _____

Please read: all charges are due at the time of service. The patient or guarantor is responsible for furnishing insurance claim information and referral to our office. All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance carrier payments.

I hereby authorize A-Team Physical Therapy LLC. To render treatment by a licensed therapist, to furnish information to insurance carriers concerning my illness and treatments, and, hereby assign to the provider all payments for medical services rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance.

Patient/Guarantor Signature: _____ Date _____

A-TEAM
PHYSICAL THERAPY

Patient Name_____ Employer _____

Insurance ID# _____ SS# _____

It is the patient's responsibility to maintain all prescriptions, referrals, and authorizations as required by your insurance company. We will bill your insurance carrier as a courtesy to you in cooperation with ***Advanced Medical Billing Solutions, Inc.***

I hereby instruct and direct _____ Insurance Co. to pay by check made out to and mailed to:

A-Team Physical Therapy
99 Northfield Ave.
W. Orange, NJ 07052

In the event that my current policy prohibits direct payments to providers, I hereby also instruct and direct you to make out the check to me and mail it as follows to:

A-Team Physical Therapy
99 Northfield Ave.
W. Orange, NJ 07052

For the professional or medical expense benefit allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. If I receive payment and an explanation of benefits, from my insurance company, I will return the check and the explanation immediately to A-Team Physical Therapy to be applied to my outstanding balance for services. **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 service charges over and above this insurance payment. I will be responsible for all costs of collecting monies owed including original charges, interest, collection agency fees, and attorney fees.

Workers Compensation: The above does not apply. However, be advised if you claim Worker's Compensation benefits and are subsequently denied, you will be responsible for any remaining balance on your account. At that time, our financial policy will apply to you.

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

This patient authorizes the provider to deposit checks received on patient's account when made out to the patient.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize this provider and Advanced Medical Billing Solutions to act on my behalf to collect monies due to A-Team from any source and to initiate a complaint to the Department of Banking and Insurance for any reason.

Signature _____ Date _____

Witness _____