OUTPATIENT THERAPY TREATMENT AGREEMENT

NAME: *(Last)* _____ *(First)* _____ *(Middle Initial)* _____

Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

DOB: _____ SS#: _____ Work Phone: _____

Place of Employment: _____ Email: _____

Sex: M F Martial Status: S M W D Last Date Seen by Referring M.D._____
(Medicare patients ONLY)

PRIMARY INSURANCE: _____ ID#: _____

Subscriber Name: _____ Group#: _____

SECONDARY INSURANCE: _____ ID #: _____

Subscriber Name: _____ Group #: _____

REFERRING PHYSICIAN: _____ Phone #: _____

RESPONSIBLE PARTY/<u>SPOUSE</u>: _____ DOB: _____

SS#: _____ Place of Employment: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

EMERGENCY CONTACT: _____Relationship: _____

Address: _____City: _____State: _____Zip: _____

Home Phone: _____Work Phone: _____Cell Phone: _____

***Whom we should thank for referral:* _____**

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IMPORTANT! PLEASE READ AND INITIAL

_____

I hereby authorize any insurance company to pay the proceeds of any benefits due to be directly sent to Beyond Physical Therapy, PLLC, 9257 Middlebrook Pike, Knoxville, TN 37931.

I acknowledge and understand that I am responsible for all charges for all the services rendered to me or to any member of my family even though I have requested insurance billing on my behalf. **I agree to make payment in full of my portion not paid by insurance (deductible, co-pay, co-insurance, non-covered items) within <u>30 days from the date of the first bill</u> unless otherwise arranged with the Business Manager of BPT. After that period the unpaid balance will increase 20% and farther delay over 60 days will cause 30% increase of the balance. The account older than 90 days will be transfer to the collection agency on my expense of 40%.** Please be courteous and cancel or reschedule appointments 24-hours in advance.

I have personally or through my physician requested rehabilitative services. I hereby authorize release of medical records to other medical agencies or my attorney as necessary.

I certify that the information given to file for Insurance payment is correct, and I request such payment to be made directly to Beyond Physical Therapy, PLLC.

_____ _____

Patient or responsible party signature *date*