# PERSONAL INFORMATION FORM AND BILLING QUESTIONNAIRE

**FILL OUT ALL FORMS, PLEASE PRINT CLEARLY**

Patient's Name (include middle initial):_______________________________________________

Patient's Social Security Number:__________--___________--___________ Age:___________

Gender:________________________ Date of Birth:________/________/________

Address: Street_______________________________________________________________

City__________________________State____________Zip___________ Phone: ( )_____--_________

Employer Name:__________________________________________ Work Phone: ( )______--_________

Work Address: Street:_____________________________________ City ___________________________

State________________ Zip__________

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**This injury is related to: (check one)** Auto Accident:________ Work related injury________ Other:________

**Brief description of your accident or incident leading to your injury:**

______________________________________________________________________________

______________________________________________________________________________

**If you have a lawyer involved in this case:**

Lawyer/Firm Name:____________________________________________Phone: ( )____________________

Address: Street____________________________________________City_____________________

State:____________ Zip:____________

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**Insurance and Health Care Provider Information:**

**Primary Care Physician:**________________________________ **Phone:** ( ) ______________________

**Primary Care Physician's Practice/Office:** ________________________________ **Location:** __________________

Primary Insurance Company: ____________________________________________

Secondary Insurance Company: __________________________________________

**Please be sure to provide the office manager with all personal health insurance cards and information. This includes automobile insurance cards and claim numbers and adjusters where appropriate.**

**PLEASE SEE OTHER SIDE**

**PLEASE READ CAREFULLY AND SIGN:**

Our chief concern is the well being of our patients and that they receive the best physical therapy management. We strive to find out the limits and extent of insurance coverage for our patients, depending on the type of insurance the patient has, to assist the patient in understanding how we assess our professional fees for services, how much of our bill is the responsibility of the insurance company and how much is the patient's responsibility. Our fees for professional services are customary and reasonable and are in line with what is generally accepted by insurers.

Your signature below signifies that you:

1. understand your eligibility and the limits of your insurance benefits for physical therapy;

2. understand the concepts of insurance deductibles and co-payments and how they apply to you for physical therapy;

3. understand and agree that you are responsible for paying your insurance deductibles if they are outstanding and co-payments as stated on explanation of benefit statements received from your insurance company;

4. acknowledge that some insurance companies, such as Blue Cross/Blue Shield Major Medical sends the benefits check directly to the patient, and that you agree to remit the amount of that check to our office;

5. authorize that your insurance company make payment for professional services directly to our office; and,

6. authorize release of any medical information necessary to process all claims including, for **medicare patients,** that payment of medicare benefits be made to Ft. Washington Rehabilitation & Fitness Center for any services furnished to you; and further that you authorize any holder of medical information about you to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits for related services.

In signing this form, I am stating that I understand and agree with the conditions of the above statement.

____________________________________ ______/______/______

**Signature** **Date**