RAINIER FAMILY
physical therapy, ps

**Patient Information**

Name: _____ MI: _____ Gender: ☐ Male ☐ Female

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____ Appointment Reminders: ☐ Text ☐ Email ☐ None

DOB: _____ Last 4 of SSN: _____ Referring MD: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Whom may we thank for telling you about RFPT? _____

**Patient Insurance**

Primary Insurance: _____ Policy: _____ Group: _____

Primary Subscriber: _____ DOB: _____ Phone: _____

Secondary Insurance: _____ Policy: _____ Group: _____

If MVA or L&I: Insurance: _____ Case Manager: _____

Claim #: _____ Accident/Injury Date: _____

Attorney (if involved): _____ Phone: _____

**Treatment Consent and Financial Responsibility**

I voluntarily give Rainier Family Physical Therapy, PS (abbreviated as RFPT) my consent to render treatment, furnish information and medical records to my physician(s), insurance carrier(s), appeal claims denied by my insurance company on my behalf, attorney or employer concerning myself or my dependent's illness and treatment. I hereby assign to the provider all payments for medical services rendered to myself or my dependents. I understand that **my insurance does not guarantee payment** and I am responsible for any amount not covered by insurance and will not withhold or delay payment. I authorize RFPT to remind me of my appointments by my selected method indicated above knowing it may not be secure.

_____ _____ _____

Patient Signature Parent/Legal Guardian Signature Date

**Worker's Compensation (L&I) and Motor Vehicle Accident (MVA) Claims**

RFPT will bill your open, approved worker's compensation or MVA claim. In the event that your claim is denied, you are financially responsible for all charges. If you are receiving treatment at another facility at the same time you are being treated at RFPT, you are responsible for keeping track of your authorized visits. In the event that you exceed your authorized visits as a result of treatment at another facility, you will be financially responsible for any denied visits.

Responsible Party Initials _____

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**Summary of Privacy Practices (HIPAA) and Patient Release of Information**

I authorize that I have received a copy of, read, and fully understand Rainier Family Physical Therapy's (abbreviated as RFPT) Notice of Privacy Practices. I attest that I have been provided with a copy of the summary of privacy practices from RFPT. I understand that RFPT may use or disclose my personal health information in order to treat me or to assist other healthcare providers treating me. I understand that RFPT will use and disclose my health information to obtain payment for services rendered or to allow insurance companies to process insurance claims for services rendered to me by RFPT or other healthcare providers. Finally, RFPT may disclose my health information for certain limited operational activities such as quality assessment, licensing, accreditation and training of students. I hereby consent to the use and disclosure of my personal health information for purposes as noted in Rainier Family Physical Therapy's Notice of Privacy Practices.

I authorize Rainier Family Physical Therapy, through its appropriate personnel, to communicate with_____ _____(name), who is my _____ (relation) regarding my appointments, medical records, and billing for services rendered on my behalf. I grant Rainier Family Physical Therapy to leave a message regarding my upcoming appointments, treatment related issues, and account information at the following numbers:

Phone:_____ with (name):_____

Phone:_____ with (name):_____

Responsible Party Initials: _____

**Insurance and Financial Policy**

I hereby assign all medical benefits to which I am entitled to Rainier Family Physical Therapy, PS in the event they file insurance claims on my behalf. I understand that I am financially responsible for all charges whether or not they are paid by my insurance. **I understand that RFPT strongly encourages me to check my benefits with my insurance company**. Should I decide not to check my benefits, I understand that any fees accrued that the insurance company does not pay will be my responsibility. **I understand that all co-pays and co-insurance payments are due at the time of service.** I understand that the following is only a summary of the financial agreement and that I have been provided with a full copy of the financial agreement and its terms.

- If I have more than $1000 owing towards my insurance plan deductible, I will be required to make payment toward the deductible based on RFPT's cash pay pricing at each date of service (currently, $80/visit). My insurance will be billed as usual and made aware of the payments made.
- I will receive a billing statement from RFPT after my insurance company has processed my claim and I have a balance. Any balance that my insurance does not cover will be "Patient Responsibility" and will be due *in full* upon receipt of my bill. If I fail to pay a bill within 3 months, and outside collections agency will be contacted.
- All balances are due and payable upon receipt of my statement from RFPT. If my account becomes 30 days past due, a $10 re-billing fee will be added to my account and will continue to be added every 30 days until my balance is paid. I will also incur a minimum $30 non-sufficient funds (NSF) fee for my account for any returned check.
- If I fail to notify RFPT of a scheduling conflict by 3 PM the day prior to my appointment or fail to show up to an appointment, I will be charged a $50 "No-Show Fee." **I understand that it is ultimately my responsibility to be aware of my appointment times**. The automated reminder system supplied by RFPT is a courtesy but I am responsible for knowing my appointment times should I be notified falsely. If the fee is not paid and goes into a billing cycle, it will incur the administrative fee as above.

I have read the above statement and have been given a copy of the Rainier Family Physical Therapy Financial Policy.

Responsible Party Initials:_____