Copay/Coins:
$ _____

Rocky Hill Office
506 Cromwell Ave
Suite 103
Rocky Hill, CT 06067

Suburban Physical Therapy & Sports Medicine Center, LLC

Cromwell Office
154 West St
Building 3, Suite H
Cromwell, CT 06416

Phone: 860-721-9801

PATIENT INFORMATION

Date: _____ **Social Security #**: _____ **Date of Birth**: _____ **Age**: _____

Name: _____

Address: _____ **City**: _____ **State**: _____ **Zip Code**: _____

E-Mail Address: _____

Home Phone: _____ **Work Phone**: _____ **Cell Phone**: _____

Sex: Male / Female **Please circle one**: Single / Married / Divorced / Widowed / Separated

Employer: _____ **Occupation**: _____

Business Address, City and Zip Code: _____

How did you hear about us? _____

Insurance Verification (Deductible, Co-pay, Co-Insurance %, # of visits allowed, authorization requirement.): _____

_____

PRIMARY INSURANCE

Primary Health Insurance: _____

Person Responsible for Account: _____ **Relationship**: Self / Spouse / Parent

Date of Birth: _____ **Social Security #**: _____

Responsible Party Employed By: _____ **Business Phone**: _____

Business Address, City & Zip Code: _____ **Occupation**: _____

Subscriber ID #: _____ **Group #**: _____

SECONDARY INSURANCE

Secondary Health Insurance: _____

Person Responsible for Account: _____ **Relationship**: Self / Spouse / Parent

Date of Birth: _____ **Social Security #**: _____

Responsible Party Employed By: _____ **Business Phone**: _____

Business Address, City & Zip Code: _____ **Occupation**: _____

Subscriber ID #: _____ **Group #**: _____

Please circle one of the following: ****Motor Vehicle Injury / **Workman's Comp. Injury / **Other Liability Injury / N/A**

**Date of Accident: _____ Claim Number: _____

**Contact Person / Adjuster: _____ Phone #: _____

**Insurance Company: _____

**Attorney's Name: _____ Phone #: _____

Office use only: Rocky Hill Office or Cromwell Office

Right * Left * KX

Patient Code: _____ Dx 1: _____ _____

Primary Insurance Code: _____ Dx 2: _____ _____

Secondary Insurance Code: _____ Dx 3: _____ _____

Referring MD: _____ Script Date: _____ Dx 4: _____ _____

# of Visits: _____ Expiration Date: _____

Suburban Physical Therapy & Sports Medicine Center, LLC

MEDICAL HISTORY

Referring Physician: _____ Phone: _____

Primary Care Physician (if different then referring MD): _____ Phone: _____

What part of the body did your physician refer you for (please circle any that apply): **Back / Neck / Shoulder / Hip / Knee / Arm / Other**

Date of first symptom / injury: _____ **Briefly describe your symptoms**: _____

_____

Have you had physical, chiropractic, occupational, or speech therapy this year? _____

*If yes, please indicate which therapy, when, and problem: _____

Medications presently on: _____

Allergies: _____

Please indicate if you have the following: HIV/AIDS: Yes / No Hepatitis Type _____: Yes / No

Pregnancy Possibility: Yes / No Pacemaker: Yes / No Seizures: Yes / No

Please circle all activities you participate in: Walking / Running / Aerobics / Golf / Tennis

Other: _____

EMERGENCY CONTACT LIST

Please indicate family members and/ or friends and your primary physician for *emergency contacts:*
****these people will also be granted access to your medical records****

1 _____ Primary Care Physician Phone #: _____

2 _____ Relationship: _____ Phone #: _____

3 _____ Relationship: _____ Phone #: _____

4 _____ Relationship: _____ Phone #: _____

This list will be valid for 1 year from date signed.

Patient's Signature: _____ Date: _____

*****MEDICARE PATIENTS ONLY*****

➔ **FOR MEDICARE PATIENTS ONLY**: Have you had a nurse or someone from a home health care agency (VNA, Interim Health, Priority Care, St. Francis, Middlesex Hospital or other) come to your house for ***any*** reason this year (please circle one)? **Yes** **No**

If **YES**, please indicate facility and discharge date**: _____

_____

_____

****Medicare will *NOT* pay for out-patient physical therapy services if you are currently having or start home healthcare services. You need to be fully discharged from your home health care agency in order to start out-patient physical therapy.**

****Medicare views the patient using home healthcare as HOMEBOUND!.****

Suburban Physical Therapy & Sports Medicine Center, LLC

PAYMENT INFORMATION AND MEDICAL RELEASE

BILLING AND PAYMENT

Suburban Physical Therapy and Sports Medicine Center, LLC, as a ***COURTESY*** to you, will submit your insurance claims for reimbursement: (**Providing all information on the patient information form is complete, up to date and all referrals are obtained**). **If we encounter any problems with your insurance claims, we will contact you for your assistance. If you do NOT respond to our request and/or if your insurance does NOT fix the error, you will be financially responsible for this difference.** ***(**Office Policy: If you have Medicare as a secondary to another health insurance, it will be your responsibility to submit the claim to Medicare on your own. Our office will NOT submit claims to Medicare if secondary.)***

YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR BILL NO MATTER WHAT YOUR INSURANCE MAY BE.

Payment is expected at the time of service for any co-pay, deductible, or percentage not covered by your insurance company.

WE ACCEPT: Cash / Checks / Money orders / VISA OR MASTERCARD.

If payment is not received from your insurance carrier within 30 days of your treatment, it is your responsibility to pay the outstanding balance

CANCELLATION / RESCHEDULING / NO SHOW POLICY

We ask that you please notify us if you cannot make your scheduled appointment. Failure to do so will result in a ***$25 charge billed to you***, not your insurance company.

PRIVACY AND RELEASE OF INFORMATION

This authorization or photocopy thereof, will authorize the representatives of Suburban Physical Therapy and Sports Medicine Center, LLC to release any information regarding my condition, including pertinent medical history, clinical findings, and prognosis, to my referring physician, insurance carrier, and/or attorney in order to facilitate the processing of my claim for physical therapy services.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

I also acknowledge financial responsibility for the services provided and hereby authorize payment of insurance benefits, other wise payable to me, directly to Thomas M. Sweeney, PT (Owner)/ Suburban Physical Therapy and Sports Medicine Center, LLC.

*****MEDICARE PATIENTS:*** I understand and agree to pay for any bills Medicare and/or my secondary insurance denies or is not allowed, because of home health care services I received.**

I hereby certify that all this information is true and accurate. A 24 hour notice is requested for any additional information not given to us on the day of your evaluation. Failure to do so will result in termination of all subsequent appointments and notifications of non-compliance to your physician and/or attorney.

Patient's Signature: _____ Date: _____

(Parent / Guardian, if patient is under 18 years of age)