RODNEY K. SHOREY

REHABILITATION SERVICES, INC.

PLEASE FILL OUT COMPLETELY & LEGIBLY

LAST NAME	FIRST	MIDDLE	DATE OF BIRTH	AGE	SEX	PHONE CONTACTS
						HOME
HOME ADDRESS			SS#			WORK
						CELL
CITY	STATE	ZIP	DRIVER'S LICENSE			EMAIL

OCCUPATION	EMPLOYER	CONTACT PERSON NOT LIVING WITH YOU	RELATIONSHIP
WORK ADDRESS		CONTACT PERSON ADDRESS	PHONE

CITY	STATE	ZIP	CITY	STATE	ZIP

ORDERING PHYSICIAN _____ PHONE _____

HOW WERE YOU REFERRED TO OUR OFFICE?

☐PHYSICIAN ☐FRIEND / RELATIVE _____ ☐INSURANCE ☐WEBSITE ☐PHONE BOOK ☐ NOTICED BUILDING

PRIMARY INSURANCE	INSURANCE ID#	SUBSCRIBER'S NAME [if other]	DATE OF BIRTH	SS#
SECONDARY INSURANCE	INSURANCE ID#	SUBSCRIBER'S NAME [if other]	DATE OF BIRTH	SS#

WORK COMP & PERSONAL INJURY ONLY: INJURY TYPE ☐WORK ☐AUTO ☐HOME ☐ OTHER INJURY DATE_____

CLAIM NUMBER _____ AUTHORIZATION NUMBER _____ LAWYER INVOLVED ☐YES ☐NO

ATTORNEY NAME _____ ADDRESS _____ PHONE _____

CONSENT FOR TREATMENT: I do hereby authorize and give my consent to Woodland Hills Physical Therapy to furnish physical therapy care and treatment for my condition(s).

FINANCIAL POLICY: Payment for services is due at the time services are rendered. We accept cash, check, credit card, and assignment of insurance benefits once benefits are verified.

PLEASE REALIZE:

1. As therapy providers, our relationship is with you and not with your insurance company or other third party payors. Your insurance is a contract between you and your insurance company; we are not a party to that contract. We bill your personal insurance carrier solely as a courtesy to you. You are financially responsible for all charges whether or not paid by insurance.
2. Not all services are a covered benefit in all contracts. We suggest you contact your insurance company if you have any questions regarding coverage.
3. Acceptance of assignment of benefits does not relieve you of your responsibility to pay deductibles, co-payments or non-covered services.
4. If any payment is made directly to you by the insurance company for services billed by us, you recognize an obligation to promptly remit the payment(s) to Woodland Hills Physical Therapy.
5. If a third party or other liable party is billed in addition to your primary health insurance and any payment is made directly to you for unpaid portions of services billed by us, you recognize an obligation to promptly remit the payment(s) to Woodland Hills Physical Therapy.
6. Balances older than 30 days may be subject to additional fees and interest charges of 1.5% per month (but not less than $5.00 after the initial 30 days or $15.00 for future months), dating back to the date of services rendered. If formal Collections procedures become necessary, you will be responsible for additional costs incurred.
7. A $25.00 fee will apply to any returned checks.

AUTHORIZATION: I authorize the release of any medical or other information necessary to any insurance company, adjuster or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize and direct payment of medical benefits to: RODNEY K. SHOREY REHABILITATION SERVICES, INC. or WOODLAND HILLS PHYSICAL THERAPY for services provided. 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.

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

CANCELLATION & NO-SHOW POLICY: We require 24 hours notice in the event of a cancellation. The charge for cancellation or no-show without proper notice is $50 per visit. This charge will not be covered by insurance, and will have to be paid by you personally prior to receiving additional treatment. Patients who fail to attend their scheduled appointments may be required to schedule same day appointments only or may be discharged from therapy.

I understand the above and agree to all the information on this sheet.

PATIENT / GUARDIAN SIGNATURE: _____ DATE: _____