

**Premier Action Therapy, Inc.
Patient Information Form (Please Print)**

Patient Information				
Patient Name (Last, First, MI)	Sex	Marital Status	Date of Birth	Social Security No.
Street Address	City, State, Zip		Home Phone	
Employer	Employer Address		Work Phone	
Email Address		Cell / Alternative Phone		

Guarantor / Guardian Information (Responsible Party)				
Guarantor / Guardian Name	Sex	Relationship to Patient	Date of Birth	Social Security No.
Street Address	City, State, Zip		Home Phone	
Guarantor / Guardian Employer	Employer Address		Work Phone	

Other Information				
Referring Doctor (Name, Location)				
Family doctor (Name, Location)				
Emergency Contact	Employer Address		Work Phone	

Primary Health Information				
Primary Carrier Name	Mailing Address			
ID No.	Group No.	Employer		
Policy Holder	Sex	Relation to Patient	Date of Birth	Social Security No.

Secondary Health Information				
Secondary Carrier Name	Mailing Address			
ID No.	Group No.	Employer		
Policy Holder	Sex	Relation to Patient	Date of Birth	Social Security No.

Workman's Compensation				
Carrier Name	Mailing Address			
Claim No.	Date of Accident		Adjuster's Name / Phone No.	

Automobile Accident				
Carrier Name	Mailing Address			
Claim No.	Date of Accident		Adjuster's Name / Phone No.	

Attorney Information (Workman's Compensation or Automobile Accident)				
Attorney Name				
Attorney Address				
Phone	Fax		Email	



How did you hear about us? _____

I certify that the above information is correct. I understand that I am personally responsible to pay all charges for services rendered to me and agree to make payment, thereof, when due. Any billing sent by the provider to an insurance company, attorney, or other third party is for the accommodation of the patient and does not relieve the undersigned to pay charges for services provided. If it is determined by the Worker's Compensation Board that the illness or condition is not a result of a compensable Worker's case, I agree to pay Premier Action Therapy, Inc for services rendered. I authorize payment for these services be paid directly to Premier Action Therapy, Inc.

Signature _____ Date _____

Premier Action Therapy, Inc.

CONSENT FOR CARE AND TREATMENT

I the undersigned, having legal authority to do so, do hereby agree and give consent for *Premier Action Therapy* to furnish medical care and treatment to _____ as considered necessary and proper in diagnosing or treating my/his/her condition.

BENEFIT ASSIGNMENT / RELEASE OF INFORMATION

I hereby assign all medical benefits, including major medical benefits, Medicare, private insurance and any other health plans to which I am entitled to *Premier Action Therapy*. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize the release of all information necessary, including Medical Records, to secure payment.

FINANCIAL POLICY STATEMENT

Premier Action Therapy bills your insurance carrier as a courtesy to you, although you are responsible for the entire bill when services are rendered. We require that arrangements for payment of your estimate portion of the bill be made today. This includes co-payments, co-insurance, and deductibles if required by your health insurance carrier. If you insurance carrier does not remit payment within 60 days, the balance will be due in full from you. If any payment is subsequently made by your insurance carrier in excess of the balance of your account, we will promptly refund the credit.

If any payment is made directly to you for services billed by us, you agree to promptly remit the payment to *Premier Action Therapy*.

The above does not apply for those patients covered by the Workers' Compensation Act. However, a Workers' Compensation patient may be responsible for the charges if the claim is denied.

In the event my balances remain unpaid for any reason, I agree to pay a penalty of 30% of the open balance to cover collections agency fees and/or attorney fees in addition to court costs.

SCHEDULING AND CANCELLATION POLICY

Premier Action Therapy reserves the right to bill a \$30 no show fee **if we are not notified** that you are unable to attend your scheduled appointment. If you cannot attend your scheduled appointment time, we ask that you notify us **24 hours** prior to your appointment so we may accommodate other patients. Consistency in treatment is important to your rehabilitation outcome and multiple cancellations may result in termination of your treatment or a loss of desired schedule time.

Patient/Guardian/Responsible Party: _____ Date _____



ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received the Notice of Privacy Practices from Premier Action Therapy, Inc. This notice is dated April 14, 2003

X _____ **Date:** _____

In lieu of patient signature, I, _____, a staff member of Premier Action Therapy, Inc, state that has been given our current Notice of Privacy Practices.

X _____ **Date:** _____