CLIFTON PARK
PHYSICAL THERAPY
KRISTINE M. WANMER, P.T. & ASSOCIATES

4 Emma Lane · Suite 401 · Clifton Park, New York 12065 · Tel. (518) 383-2610 · Fax (518) 383-8188

Patient Name: _____DOB: _____SSN: _____

Address: _____City: _____State: _____Zip: _____

Phone: (home) _____ (cell) _____(work) _____

Email address:_____

Employer: _____Occupation: _____Currently working**:** Yes/No_____

Employer Address: _____

Marital Status: (*circle one***)** MARRIED SINGLE DIVORCED WIDOWED **Patient Sex**: ( ) Male ( ) Female

Emergency Contact Name: _____Phone:_____

If patient is a minor, Guardian please complete the following:

Guardian Name: _____ Relation to patient_____

Address: _____City: _____State: _____Zip: _____

Phone: (H) _____(C) _____ (W) _____ SSN: _____

Insurance Information:

Primary Insurance Company: _____ Copay amount: $_____

ID#:_____Group#:_____

Subscriber Name: _____ DOB: _____ Employer: _____

Relationship to patient: _____Male/Female_____

Secondary Insurance Company: _____Copay amount: $_____

ID#: _____Group#:_____

Subscriber Name: _____DOB: _____Employer: _____

Relationship to patient: _____Male/Female_____

No-Fault Insurance Company:

No-Fault Carrier Name: _____ Accident Date: _____

Address: _____City: _____State: _____Zip: _____

Policy #: _____Claim #: _____

Phone #: _____Policy Holder Name: _____

Worker's Compensation:

Work Comp Name: _____Injury Date: _____

Address: _____City: _____State: _____Zip: _____

Phone #: _____Claim #: _____Adjusters Name: _____

Experience The Difference

Hours of Operation: 7:30am – 7:30pm Mon-Thu • 7:30am – 5pm Fri • 8am – 12pm Sat

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PAYMENT POLICY

I understand that payment is expected *at time of service* for my co-payment, co-insurance or deductible.

My Co-pay $_____ Per visit

Deductible? ( ) Yes ( ) No **Contracted Rate with your insurance:** Evaluation $_____

Contract Rate with your insurance: Follow up visits $_____ea.

If there is not a contracted rate with your insurance, we will bill you for your deductible or co-insurance.

When Medicare is primary, we will bill you for any balance not paid by your insurance company/companies.

Patient/ Guardian Initials_____

CONSENT TO TREAT

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize the release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. If I fail to give correct insurance information or if my insurance has terminated or denied, I am responsible for any charges incurred. **I authorize release of payment directly to *Clifton Park Physical Therapy* from my insurance carrier**, regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.

Patient/Parent/Guardian Signature: _____ ***Date:*** _____/_____/_____

HIPAA

I acknowledge that I have seen the ***"Notice of Privacy Practices."*** I understand that I may ask about the ***"Notice of Privacy Practices"*** at any time.

Please list the names of anyone whom might call to inquire about your health or a bill. If no one is listed, we will only be allowed to speak to you, your referring physician, and the insurance company covering your care. This may be a family member or close friend.

_____/_____

_____/_____

Patient/Parent/Guardian Signature: _____***Date:*** _____/_____/_____

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Cancellation & No-show Policy Resulting in $30.00 Fee

Our goal is to provide quality medical care in a timely manner. In order to do so we have a 24-hour cancellation policy that will result in a $30.00 fee. The policy enables us to better utilize available appointments for our patients in need of medical treatment.

Cancellation of an Appointment

We understand changing schedules. In order to be respectful of others, please be courteous and call promptly if you are unable to attend. Appointments are in high demand, and your early cancellation will give another person the possibility to be seen. If it is necessary to cancel your appointment, we require that you call 24-hours before your scheduled appointment.

How to Cancel and Reschedule Your Appointment

To reschedule appointments please call (518) 383-2610. If you do not reach a receptionist, you may leave a detailed message on the voicemail. You may also cancel an appointment when you get a "text reminder" or our automated "phone call reminder", by following the directions given on the message. You may select to "opt out" of the text and phone call reminders. If you cancel via the "Text Reminder", this still needs to be done within 24 hours of the appointment time or you will be charged a $30.00 fee.

Late Cancellations

Late cancellations and reschedules, made less than 24 hours prior to your appointment time, will be considered a "NO-SHOW", and will result in a $30.00 fee that is due on your next scheduled appointment. This is not a covered expense by your insurance carrier, as you are responsible for making and changing appointments. Your insurance carrier will only pay for visits you have received.

No Show Policy

A "No-show" is someone who misses an appointment without canceling 24 hours in advance. No-shows inconvenience those individuals who need medical care. A failure to present at the time of a scheduled appointment will be recorded in the patients' chart as a "no show". You will be liable for a $30.00 fee that is due on the next scheduled visit. Three "no shows" will result in the suspension of services and you will be discharged from Clifton Park Physical Therapy, and your doctor will be notified of your non-compliance.

(Patient: Please keep this for your records)

Thank you,

Kristine Wanmer, PT (Owner)