AUTHORIZATION TO TREAT/PATIENT INFORMATION

LAST NAME:______________________________________ FIRST NAME:________________________________ M.I. ____

ADDRESS:_______________________________________CITY: ___________________STATE/ZIP________________________

HOME PHONE:___________________________________ WORK PHONE:____

CELL PHONE:____________________________________ SEX: MALE FEMALE

SOCIAL SECURITY #:______________________________ MARITAL STATUS: MARRIED DIVORCED WIDOW SINGLE

DATE OF BIRTH:__________________AGE:____________ EMERGENCY CONTACT:___________________________________

STUDENT: NO PART TIME FULL TIME EMERGENCY CONTACT PHONE:____________________________

EMPLOYER:______________________________________ E-MAIL:____

HOW DID YOU HEAR ABOUT US? ☐ SIGN ☐ INSURANCE DIRECTORY ☐ MD REFERRAL ☐ ANOTHER PATIENT ☐ THE POST

REFERRING PHYSICIAN: ___________________________ ARE YOU CURRENTLY RECEIVING HOME HEALTH? ☐ YES ☐ NO

PHYSICIAN PHONE: _______________________________ PHYSICIAN FAX: ___________________________________

PATIENTS RELATIONSHIP TO SUBSCRIBER: ☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

SUBSCRIBERS NAME: __________________________________ SUBSCRIBERS SOCIAL SECURITY #:____________________

PRIMARY		SECONDARY
	(PLAN NAME)	
	(PHONE #)	
	(POLICY/ID #)	
	(GROUP #)	

DO YOU HAVE AN ATTORNEY FOR THIS CLAIM? ☐ Y ☐ N IF YES, NAME:____

WAS THIS A MOTOR VEHICLE ACCIDENT? ☐ Y ☐ N NAME OF MOTOR VEHICLE INSURANCE:_______________________

ADJUSTER NAME:_______________________________ PHONE #:______________________ CLAIM #: _________________

PLEASE INITIAL THE FOLLOWING:

______ I CERTIFY THAT THE INFORMATION I HAVE PROVIDED IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE.

______ I HEREBY ASSIGN ALL INSURANCE BENEFITS FOR SERVICES RENDERED TO WHICH I AM ENTITLED TO BE PAID DIRECTLY TO HOPS THERAPY SERVICES. I UNDERSTAND THAT IF MY INSURANCE COMPANY/THIRD PARTY PAYOR DENIES PAYMENT OR MAKES PARTIAL PAYMENT, THAT I AM RESPONSIBLE FOR THE BALANCE. I UNDERSTAND THAT I WILL BE CHARGED A LATE FEE IF MY ACCOUNT BALANCE IS NOT PAID IN FULL BY THE DUE DATE OF MY PATIENT BILLING STATEMENT. NAME OF BANKING INSTITUTION:____.

______ I HEREBY AUTHORIZE THE RELEASE OF MEDICAL RECORDS TO HOPS THERAPY SERVICES AND ANY PERTINENT INFORMATION CONCERNING THE PATIENT FOR THE PROVISION OF CARE AND FOR OBTAINING INSURANCE REIMBURSEMENT.

______ I ACKNOWLEDGE READING AND UNDERSTANDING THE HOPS NOTICE OF PRIVACY PRACTICE THAT IS POSTED IN THE WAITING ROOM. HOPS THERAPY SERVICES RESERVES THE RIGHT TO MODIFTY THE PRIVACY PRACTICES OUTLINED IN THE NOTICE.

______ I UNDERSTAND AND ACKNOWLEDGE READING THE FINANCIAL POLICY POSTED IN THE WAITING ROOM THAT I AM LEGALLY RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED BY HOPS THERAPY SERVICES. IF MY INSURANCE IS BEING BILLED, I WILL BE RESPONSIBLE FOR PAYING ANY DEDUCTIBLE AMOUNTS. I UNDERSTAND THAT CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE. (THIS DOES NOT APPLY TO WORKER'S COMPENSATION PATIENTS.)

______ I UNDERSTAND AND ACKOWLEDGE READING HOPS THERAPY SERVICES CO-PAY AND ATTENDANCE POLICY IN TERMS OF PAYMENT FOR HIGH DEDUCTIBLES AND THE **$25.00 FEE FOR NO SHOW/24 HOUR CANCELLATION POLICY**.

SIGNATURE OF PATIENT/GUARDIAN: _______________________________________ DATE: ____________________________