Orofino Physical Therapy & Wellness

INSURANCE INFORMATION: Patient Name:_____

HAVE YOU HAD PHYSICAL THERAPY THIS YEAR: YES NO

Primary Insurance	
Insurance Provider:	
Identification/ Subscriber number:	
Group /Claim #:	
Insurance Phone Number:	
Insurance Address:	
Policy Effective Date:	
POLICY HOLDER name:	
POLICY HOLDER date of birth:	
POLICY HOLDER SSN:	
Relationship to Patient:	
Secondary Insurance:	
Insurance Provider:	
Identification/ Subscriber Number:	
Group / Claim #:	
Insurance Phone Number:	
Insurance Address:	
Policy Effective Date:	
POLICY HOLDER name:	
POLICY Holder date of birth:	
POLICY HOLDER SSN:	
Relationship to patient:	

Release of Information: Orofino Physical Therapy may disclose all or any part of my records to any party or organization responsible for all or part of my therapy charges. Orofino Physical Therapy may disclose all or part of my record to other health care providers including but not limited to, hospitals and physicians. I further agree that Orofino Physical Therapy, may release all or any part of my record to any federal, state, or local government body when, in the opinion of Orofino Physical Therapy, such bodies may be liable for all or part of my charges in relation to my care and treatment pursuant to statute or rule.

Financial Consent: I agree to be responsible for payment of all outpatient physical therapy charges which are not covered by insurance, and when appropriate, to submit applications to federal, state, and county programs. I understand Orofino Physical Therapy, will bill me, my family, and/or other responsible parties for services provided.

Assignment of Insurance Billing: I and/or the responsible party voluntarily assign Orofino Physical Therapy, PLLC and its independent contracting providers the right to pursue their respective claims for reimbursement from any insurance policy or policies providing coverage for services provided.

No-Show/ Cancellation Policy: All patients who do not cancel their appointment within **24-hours** or more of their scheduled appointment will be charged **$20.00** at their next appointment. This fee can be waived for patients who re-schedule their appointment within that week. Patients who do not show up to their appointment and do not call to cancel will receive a **$25.00** "No-Show" fee.

_____ Date: _____/_____/_____

Signature/ Responsible Party