Hot Springs Health Program

# Outpatient Physical Therapy Intake Form

Mashburn Medical Center • 590 Medical park Drive • Marshall • North Carolina • Phone (828) 649-1775

First Name: _____ MI: _____ Last Name: _____ Sex: _____

DOB: _____ SS#: _____ Mailing Address: _____

_____ City: _____ State: _____Zip Code: _____

Primary Phone #: _____ Alt Phone #: _____Email:_____

Do you prefer (***text***), (***phone***), or (***email***) appointment reminders? (circle one)

| **Primary Insurance Information** | **Secondary Insurance Information** |
|---|---|
| Insurance Co. Name: _____ | Insurance Co. Name: _____ |
| ID#: _____ | ID#: _____ |
| Group #: _____ | Group #: _____ |
| Address: _____ | Address: _____ |
| City: _____ State:_____ Zip:_____ | City: _____ State:_____ Zip:_____ |
| Policy Holder Name: _____ | Policy Holder Name: _____ |
| Policy Holder DOB: _____ Sex: _____ | Policy Holder DOB: _____ Sex: _____ |
| *Tricare-Sponsor's SSN: _____ | *Tricare-Sponsor's SSN: _____ |
| Relationship to policy holder: _____ | Relationship to policy holder: _____ |
| Employer Name: _____ | Employer Name: _____ |

**STATEMENT OF CONSENT FOR TREATMENT:** I hereby voluntarily consent to routine medical treatment by the staff of the Hot Springs Health Program and their agents. If the patient is a minor who I am responsible for and/or the parent or legal guardian, I consent to routine medical treatment of my child. Further, I understand that specific and separate consent forms may be requested from me prior to any non-routine or hazardous treatment that is not an emergency.

**ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT:** I hereby assign my benefits and request payment of benefits for services rendered to me or on my behalf to be paid to the Hot Springs Health Program, Inc. I also authorize release of medical information to my insurance company if needed to determine eligibility of these benefits or benefits of related services. By request of the Hot Springs Health Program, Inc., payment is requested at time of service, unless other arrangements have been made in advance. Hot Springs Health program is not contracted and does not accept assignment with all insurance companies. Insurance will be filed as a courtesy for our patients. As the undersigned, I acknowledge responsibility for any remaining balances after insurance has been filed or for any non-covered services by the insurance company. The undersigned is ultimately responsible for payment.

**PRIVACY PRACTICES NOTIFICATION:** I have had the opportunity to view or obtain a copy of the Hot Springs Health Program's Notice of Privacy Practices as required by the federal Health Insurance Portability and Accountability Act.

**PATIENT RESPONSIBILITY: "I verify the accuracy of the aforementioned information and I authorize the release of information as provided above. I agree that I am fully responsible to pay all fees charged by the provider, regardless of how much insurance pays. I acknowledge that the provider may not be contracted nor accept assignment with my insurance carrier. If the provider accepts assignment, the deductible and copayments are my responsibility."**

**"I UNDERSTAND THAT ALL COPAYS ARE TO BE PAID AT THE TIME OF SERVICE."**

**Signature:** _____ **Date:** _____

*(Patient signature (if less than 18 yrs old, parent or legal guardian signature.)*