PATIENT INFORMATION DYNAMIC PHYSICAL THERAPY PHONE: 402-905-9089
11757 S HIGHWAY 6 SUITE 1 GRETNA, NE 68028

Patient Name: _____Date of Birth_____

Age: _____ Sex: M/F Referring Physician or Referred By:_____

Home Address:_____State:_____Zip Code: _____

Home phone:_____ Work Phone:_____Cell Phone: _____

Email:_____Can we leave a voice message? Yes/No

Emergency Contact:_____Phone:_____

Work Comp: Yes/No Auto Accident: Yes/No Sports injury: Yes/No Other

GUARANTOR INFORMATION (PERSON RESPONSIBLE FOR BILL)

Name:_____Date of Birth: _____

Relation to Patient: _____

Home Address: (If different from above) _____

Home Phone: _____Work Phone: _____Cell Phone: _____

PRIMARY INSURANCE INFORMATION

Ins. Company:_____Group#:_____Policy #:_____

SECONDARY INSURANCE INFORMATION

Ins. Company:_____Group#:_____Policy#_____

Insurance: An insurance policy is a patient's responsibility. You are responsible to know what your insurance does and does not cover. If you have questions, please call the number on your card. If you have questions about cost of services, please feel free to ask and we can give you an estimate of cost. It is an estimate only.

Authorization to Treat: I authorize and direct the physical therapists of Dynamic Physical Therapy and his/her designee to provide physical therapy services for me as deemed necessary and appropriate. I understand that I have the right to receive information, to request treatment, and to seek a second opinion. Patients 19 years and younger must be accompanied by a guardian at his/her initial visit.

Notice of Privacy Practices: The policies and procedures of Dynamic Physical Therapy are designed to comply with the Health Insurance Portability and Accountability Act of 1996. I agree that the Notice of Privacy Practices of Dynamic Physical Therapy has been made available to me.

The undersigned patient or patient's guardian herby acknowledge to have read, understood and agreed to conditions set forth in the Authorization to Treat, Privacy Practices, Financial Responsibility, and, if applicable, Medicare Patient's Information.

Signature: _____Date:_____

Signature of Parent or Legal Guardian:_____Date:_____

Printed Name: _____

Patient Financial Responsibility Agreement

Thank you for allowing Dynamic Physical Therapy to assist you with your rehabilitation. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward that. Our goal is to make the financial aspect as stress-free as possible.

We will have our billing agency bill your insurance for you. If there are any changes to your insurance information, please let us know immediately so we can submit your claim properly. Insurance reimbursement is a contract between you, your employer and your insurance carrier. You are responsible for any charges, or portions of charges that your insurance does not pay for.

You will receive 3 paper statements from our billing agency in the mail. If we do not receive a form of payment or arrangements for payment after the 3rd statement, we will be forced to turn your billing over to a collection agency. We are obligated under law to collect any money you owe such as copayments or deductibles. If you have questions about what it may cost to come to therapy, please ask us and we will give you an estimate of charges. Please initial that you are in understanding of this. Initial _____

Please call 402-884-9612 with any questions about your bill.

Please contact the clinic if you are not able to keep your appointment at 402-905-9089. Appointments should be cancelled at least 24 hours in advance.

Fees may change at any time.

I, the undersigned:

( ) have insurance coverage, and authorize direct payment from my insurance carrier to Dynamic Physical Therapy.

Note: You are responsible for knowing your coverage benefits. Dynamic Physical Therapy will make every effort to inform you if a supply or service is not covered by your insurance.

( ) do not have insurance coverage or my insurance company is not in network at this time and understand I am responsible for payment of all charges.

Signature _____Date _____

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

Authorization

I, _____, authorize Dynamic Physical Therapy/Midwest Medical Billing to use and disclose the protected health information described below. These medical records may be used by Dynamic Physical Therapy/Midwest Medical Billing for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

Effective Period
This authorization for release of information covers the period of healthcare from:

a. ☐ Specified dates: _____ to _____.
b. ☐ All past, present, and future periods.

Health Information to Be Disclosed
I authorize the release of:

a. ☐ My complete health record (including but not limited to diagnoses, prognosis, treatment, and billing) to all that may request it.
b. ☐ My complete health record, as above, ***with the exception of*** *(please specify):*

_____

_____

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is *not* effective to the extent that any person or entity has already acted in reliance on my authorization, or if my authorization was obtained as a condition, of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed by Dynamic Physical Therapy/Midwest Medical Billing following with this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient or Representative Signature _____ Date _____

Printed Name _____

Relationship to Patient (if Representative) _____