PATIENT INFORMATION AND CONSENT

Please answer all the questions. This information is important for your health and our records.

NAME ____DATE OF BIRTH ______________AGE ______
ADDRESS ______________________________________CITY _____________________ZIP _____________
E-MAIL ADDRESS ____________________________________CELL PHONE#__________________________
SOCIAL SECURITY # ________________________________HOME PHONE#__________________________
PATIENT EMPLOYER ________________________________OCCUPATION ___________________________
ADDRESS ____
CITY ____________________________ ZIP CODE ________________PHONE # ______________________
PERSON RESPONSIBLE FOR THIS ACCOUNT ____
ADDRESS __________________________________ CITY _______________________ ZIP ______________
SOCIAL SECURITY # __________________ DATE OF BIRTH ______________ PHONE #__________________
EMPLOYER NAME & ADDRESS ____
EMERGENCY CONTACT PERSON: ____
RELATIONSHIP TO PATIENT _______________________________ **PHONE #**_________________________

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(For TRICARE Patient only) Sponsor's Date of Birth: ______________/______________/________________
MONTH / DAY / YEAR

FAMILY PHYSICIAN _____________________________________ DATE OF LAST VISIT _________________
PHONE # ___________________________
WHO MAY WE THANK FOR REFERRING YOU TO THIS OFFICE? ______________________________________

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PRIMARY INSURANCE COMPANY ____
SECONDARY INSURANCE COMPANY ____
ARE YOU CURRENTLY RECEIVING HOME HEALTHCARE? □ YES □ NO
IS THIS A WORKMEN'S COMPENSATION CASE? □ YES □ NO CONTACT PERSON ______________________
PHONE #______________________

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I certify that the above information is true and correct to the best of my knowledge- I give permission to the Physical Therapist to administer and perform such procedures as may be deemed necessary in the diagnosis/or treatment of my physical therapy. I accept responsibility for all charges incurred for this treatment, not covered by my insurance. I authorize Kingsway Physical Therapy to release all information necessary to process any insurance claims filed.

IF MY ACCOUNT IS REFERRED FOR COLLECTION, I AGREE TO PAY THE COST OF COLLECTION INCLUDING 33 1/3 COLLECTION FEE AND 50% ATTORNEY FEES IF LITIGATION IF NECESSARY.

____ ______________________________
Patient's Signature (Parent/Guardian if Minor) Date

Shola Asenuga M.S P.T

Consent for Use and Disclosure of Protected Health Information

With my consent, Kingsway Physical Therapy L.L.C., may use and disclose Protected Health Information (PHI) about me to carry out treatment, payment, and health care operations (TPO). Please refer to Kingsway Physical Therapy L.L.C, Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Kingsway Physical Therapy L.L.C. reserves the right to review its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Kingsway Physical Therapy L.L.C. Privacy Officer at the listed address below.

With my consent, Kingsway Physical Therapy L.L.C. may mail to my home or other designated locations any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. _____ Initials _____ Date

With my consent, Kingsway Physical Therapy L.L.C. may call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance and billing items as well as any call pertaining to my clinical care, including laboratory results among others. _____ Initials _____ Date

However, this practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. _____ Initials _____Date

By signing this form, I am consenting to Kingsway Physical Therapy L.L.C. Use and disclosures of my PHI to carry out TPO.

I may revoke this consent in writing except to the extent the practice has already made disclosures in reliance upon my prior consent. If I do not sign consent, Kingsway Physical Therapy L.L.C. may decline to provide treatment to me.

_____ _____

Patient Name **Date**

Kingsway Physical Therapy L.L.C.
• 208 Fox Hill Road, Ste B • Hampton, VA 23669 • (757) 325-8252

Kingsway
Physical Therapy L.L.C.

PATIENT FINANCIAL RESPONSIBILITY FORM

Patient Name: _____ ***Date***:_____

If you have ANY questions, please ask the receptionist.

1. FINANCIAL RESPONSIBILITY: We are pleased to assist with your insurance. I understand that with the exceptions explained below, I am personally responsible for any medical fees I will incur with Kingsway Physical Therapy L.L.C.

I also understand that I will be responsible for any charges incurred by not providing the most current, correct insurance to the Kingsway Physical Therapy L.L.C. Exceptions to this policy are those patients with a current authorization with an HMO, a State or Federally funded program, or a PPO in which Kingsway Physical Therapy L.L.C. is currently a contracted provider.

2. AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE Kingsway Physical Therapy L.L.C. to release medical information acquired in the course of my examination or treatment, to my insurance company, or other physicians required to participate in my care.

3. AUTHORIZATION TO PAY BENEFITS: I hereby authorize payment for medical services provided directly to the Kingsway Physical Therapy L.L.C.

4. To avoid $50.00 NO-SHOW fee, cancellation notice must be provided at least 24 hours in advance.

5. A $35.00 fee will be charged for all returned checks, regardless of reason.

6. ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY: I acknowledge that I have received a copy of Kingsway Physical Therapy L.L.C. Privacy Policy.

Signature of Patient/Legal Guardian_____ Date: _____

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