PATIENT REGISTRATION OPT #5

oxfordphysicaltherapy.com

Patient Name ______________________________
First Middle Last

Permanent Address ______________________________
Street City State Zip

Temporary Address ______________________________
Street City State Zip

Phone ______________________________
Home Work Cell

Emergency Contact ______________________________
Name Phone Relationship

Email Address ______________________________ Sex: ❑ M ❑ F

Birthdate ___/___/___ Social Security # ______________ Marital Status ❑ S ❑ M ❑ Wid ❑ Div ❑ Sep

Patient's Employer ______________________________
Phone Number

Employer's Address ______________________________
Street City State Zip

Date of Injury / Onset ______________________________
Referring Physician Family Physician

PRIMARY INSURANCE INFORMATION

____
Policyholder Name Relationship DOB SSN

Address ______________________________
(if different than above) Street City State Zip

____
Policyholder's Employer Phone Primary Insurance Company

Employer Address ______________________________
Street City State Zip

SECONDARY INSURANCE INFORMATION

____
Policyholder Name Relationship DOB SSN

Address ______________________________
(if different than above) Street City State Zip

____
Policyholder's Employer Phone Secondary Insurance Company

Employer Address ______________________________
Street City State Zip

WORKER'S COMPENSATION CLAIMS

____
Claim Number Date of Injury Employer at time of accident Phone

I will provide my Worker's Compensation claim number to you as soon as it arrives at my home. If I fail to provide my number or if my claim is denied, I will be responsible for payment.

Injured Worker's Signature ______________________________ Date ______________

I give my consent for Oxford Physical Therapy to leave a voice mail on my home/cell answering devices

❑ Yes, Patient/Authorized Representative Initial ❑ No, Patient/Authorized Representative Initial

PLEASE READ AND SIGN THE OPPOSITE SIDE OF THIS SHEET

FINANCIAL POLICY

The entire Oxford Physical Therapy team would like to thank you for making us your preferred family physical therapist and health care provider. We are committed to your treatment being successful.

All prospective patients must fill out and complete a patient information and insurance form before being seen by an Oxford Physical Therapist. Financial responsibility for treatment is an obligation to the patient. As a courtesy, Oxford Physical Therapy will verify patient coverage and bill the appropriate insurance carrier on the patient's behalf. Remaining balances after insurance payment are the responsibility of the patient and are "**Due within 90 Days of Treatment**". Prompt payment allows Oxford Physical Therapy to continue providing quality and cost effective patient treatment. Patients should contact the Oxford Physical Therapy billing department at 513.701.6100 to arrange a payment schedule if they are not able to meet their financial obligation.

Regarding Your Insurance - Important! Oxford Physical Therapy requires the patient co-payment at the time of treatment. If co-payments are not paid at the time of service a $15.00 late fee will be assessed to the patient's bill. In the event patient's insurance changes to a plan where Oxford Physical Therapy is no longer in network, refer to the above paragraph. It is the patient's responsibility to know their benefits. Disputes regarding deductibles, co-payments, covered charges, "usual and customary" charges, etc. are handled between the patient and their insurance company.

If the patient receives payment from the insurance company for services rendered by Oxford Physical Therapy, it is the patient's responsibility to reimburse Oxford Physical Therapy in full at the time of receipt of such payment.

If a patient has secondary insurance it must presented at time of service. Oxford Physical Therapy will not retroactively bill a secondary insurance if there is failure to provide all of the necessary insurance information at the time of service. The balance becomes the patient's obligation and is responsible for submitting claims to secondary insurance companies.

The patient agrees that if he or she defaults on any balance owed Oxford Physical Therapy and it becomes necessary for Oxford Physical Therapy to engage the services of an attorney, collection agency or other lawful method of collection, the patient will pay the original balance owed and reimburse Oxford Physical Therapy for all costs incurred by it in the collection of said debt.

Regarding Insurance Billing: If current and accurate insurance is provided at the time of service, Oxford Physical Therapy will bill the patient's insurance company in a timely manner. **All patient claims are due and payable within 90 days of receipt of the insurance claim form.** However, in the event that repeated billing to the patient's insurance carrier does not satisfy the patient's balance, that patient assumes the financial responsibility of the remaining balance.

Oxford Physical Therapy accepts Cash, Check, & most major credit cards. Payments may be made at any local Oxford Physical Therapy treatment center, on our website www.oxfordphysicaltherapy.com, or by calling the Oxford Physical Therapy billing staff at 513.701.6100.

***If paying by check you understand and authorize all dishonored checks plus a processing fee with applicable taxes to be charged to your account.

Missed Appointments and Late Charges: Oxford Physical Therapy requires a 24 hour advanced notice for all appointment cancellations or a $40.00 fee will be billed directly to the patient for missed appointments.

***There is a $15.00 per month late fee assessed on all unpaid balances.

Minors: The adult accompanying a minor is responsible for payment.

Auto Insurance: Oxford Physical Therapy will submit claims to patient Med Pay with your auto insurance. If patients do not have Med Pay, we will submit claims to patient's health insurance. In the event, a patient has obtained an attorney, Oxford Physical Therapy will require a letter of protection, assuring Oxford Physical Therapy's financial interests will be protected in the event that the personal injury protection benefits become exhausted.

I have read the above Financial Policy and agree that (regardless of my insurance status) I am ultimately responsible for the balance of my account for any professional services rendered by Oxford Physical Therapy.

Consent to Treat and Authorization to Release Information

I hereby authorize Oxford Physical Therapy, through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed necessary by my physician and physical therapist in the treatment of my condition. I further authorize Oxford Physical Therapy to furnish and/or disclose my personally identifiable health information to the appropriate agencies for the purpose of billing. I have had the opportunity to review Oxford Physical Therapy's Privacy Notice prior to signing this consent. I understand that I have the right to request restrictions on the uses and disclosures of my protected health information for treatment, payment and healthcare operations, but Oxford Physical Therapy is not required to agree to such a request, but if Oxford Physical Therapy does agree to my request, the restrictions will be binding. I am allowing a photocopy of my signature to be used for insurance purposes. I also authorize my insurance company to pay directly to Oxford Physical Therapy the amount due me in my pending claim for insurance.

Patient's Signature or Authorized Representative　　　　　　　　Date