

**☞ Patient Personal Information**

Married / Single

\_\_\_\_\_  
Last Name First Name Date of Birth Male / Female

\_\_\_\_\_  
Street Address City State ZIP

\_\_\_\_\_  
Home Phone Cell Phone E-Mail

\_\_\_\_\_  
Employer Occupation Work Phone #

\_\_\_\_\_  
Parent /Guardian (if minor) Emergency Contact Person and Telephone #

**☞ Primary Physician and Clinic**

**☞ How did you learn about ActivePT?**

Friends or Family Members (List all): \_\_\_\_\_

I was referred by (List all practitioners): \_\_\_\_\_

Walked by Clinic  Internet Search  RAC Member? Y or N  Ad (Please circle one): TV Radio Flyer

**☞ How will you pay for your services?**

**1. I will pay the bill myself.**

Paying your total charges by **cash, check, or credit card** entitles you to a **40% discount** at the time of service.

**2. Bill my Insurance.** \$ Yes - No - Unknown

Amount of Deductible/Co-insurance Have you met your deductible?

\_\_\_\_\_  
Name of Insurance Company (A copy of your insurance card is required at your first visit.)

\_\_\_\_\_  
Name of Insured if Different from Patient Birth Date of Insured Relationship to Patient

\_\_\_\_\_  
Employer Group # Member ID #

**3. Bill my Workman's Compensation Claim.** You must bring your proper paperwork to your first visit.

**4. Bill my auto or personal injury insurance.** Bring the responsible insurance company information.

Complete the information below:

\_\_\_\_\_  
Name of WC carrier or Auto Insurance Carrier Phone # Claim #

\_\_\_\_\_  
Contact Person Has PT visits been approved? # of Visits Approved

**Assignment of Benefits (complete if anyone other than the patient is responsible for treatment charges)**

I hereby instruct and direct \_\_\_\_\_ (primary insurance company) and \_\_\_\_\_ (secondary insurance company) to pay by check made out and mailed to: ActivePT, Corp. at PO Box 7197, Rochester, MN 55903. If this current policy prohibits direct payment to doctor, I hereby also instruct and direct you (the patient) to make out the check to me and **mail it to the above address** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

**This is a direct assignment of my rights and benefits under this policy.**

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

- A photocopy of this Assignment shall be considered as effective and valid as the original.
- I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- I authorize the use of this signature on all insurance submissions.
- I authorize ActivePT to deposit checks made in my name.
- I authorize ActivePT to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature

Date

**Consent To Be Treated**

I hereby consent to treatment by ActivePT, Corp. and agree to abide by company policies while a patient of ActivePT, Corp.

**Important policies**

- Cancellation policy: Cancellations with less than 24 hour notice or no-shows for appointments will be subject to a \$20 fee.**
- Late policy: If you are more than 10 minute late, a \$10 fee will be applied and you will be asked to reschedule.**
- Any unmet portion of your deductible is your responsibility. Payment for services applied to your deductible are due on the date of service unless payment plan arrangements have been made.
- Co-pay/co-insurance is due at the time of service unless payment plan arrangements have been made.
- Cell phones and pagers must be on vibrating or silent mode. Phone calls during treatment are prohibited.
- Children requiring supervision are not allowed to attend your appointment unless approved by your therapist.
- Our financial hardship program is available to all patients who may be undergoing special financial circumstances. This is a federal program that allows us to legally reduce the percentage of the fees that are your responsibility. Reducing co-pays, co-insurance, or portions of your bill that go to your deductible is otherwise strictly prohibited by federal and state law.

Signature

Date

**HIPAA Privacy Statement**

I hereby acknowledge that I have received a copy of ActivePT, Corp.'s privacy statement.

Signature

Date

ActivePT, Corp. Authorized Signature

Date