



1 Patient Information Form

NAME: _____ SEX: _____ MARITAL STATUS: _____ DATE OF BIRTH: ____/____/____
SOCIAL SECURITY #: ____/____/____ HOME #: _____ - _____ - _____ CELL #: _____ - _____ - _____
ADDRESS: _____ EMPLOYER: _____
City _____ State _____ Zip Code _____ OCCUPATION: _____ WORK # _____

Is your Injury do to Employment or an Automobile Accident: _____ Do you have an attorney for this case: _____
Yes No IF YES: Insurance Company: _____ Claim #: _____
Contact Person: _____ Phone #: _____

(PLEASE HAVE YOUR INSURANCE CARD(S) AND IDENTIFICATION AVAILABLE FOR FRONT OFFICE STAFF TO COPY)

PRIMARY INSURANCE
PRIMARY INSURANCE: _____
ID/MEMBER# _____
GROUP# _____
POLICY HOLDER: _____
RELATIONSHIP TO POLICY HOLDER: _____
POLICY HOLDER'S SOCIAL SECURITY #: ____/____/____
POLICY HOLDER'S DATE OF BIRTH: ____/____/____
POLICY HOLDER'S ADDRESS (IF DIFFERENT FROM PATIENT ADDRESS):
ADDRESS _____
CITY/STATE/OH _____

SECONDARY INSURANCE
PRIMARY INSURANCE: _____
ID/MEMBER# _____
GROUP# _____
POLICY HOLDER: _____
RELATIONSHIP TO POLICY HOLDER: _____
POLICY HOLDER'S SOCIAL SECURITY #: ____/____/____
POLICY HOLDER'S DATE OF BIRTH: ____/____/____
POLICY HOLDER'S ADDRESS (IF DIFFERENT FROM PATIENT ADDRESS):
ADDRESS _____
CITY/STATE/OH _____

REFERRING DOCTOR: _____
PHONE NUMBER: _____ - _____ - _____

IN CASE OF EMERGENCY CONTACT: _____
RELATIONSHIP: _____
HOME PHONE # _____ - _____ - _____
WORK OR CELL PHONE #: _____ - _____ - _____

IF THERE IS ANYONE WHOM YOU WOULD LIKE TO GIVE PERMISSION TO DISCUSS YOUR HEALTH CONDITION, PLEASE LIST BELOW:
NAME RELATIONSHIP PHONE NUMBER

How did you hear about Blue Sky?
My Doctor ___ The Phone Book ___ A Friend ___
Newspaper ___ Walk-In/Location ___ A Mailer ___
Other

PATIENT FINANCIAL RESPONSIBILITY: This agreement between NBJ Rehabilitation Services d.b.a. Blue Sky Therapy, as Creditor and the Patient/Debtor named on this form. In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our," refer to BLUE SKY THERAPY. By executing this agreement, you are agreeing to pay for all services that are received. I agree to make co-payments at time of each visit. I understand my insurance may not cover the cost of Physical Therapy. I want to receive this item or service and I will pay for it if my insurance does not cover the cost. By signing below I agree to personally guarantee payment if my insurance does not cover the cost of Physical Therapy.

MONTHLY STATEMENT/PAYMENTS: The balance on your statement is due and payable when the statement is issued, and is past due if not paid in 30 days of statement date. A late fee will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. If your account becomes past due, we will take necessary steps to collect this debt. If we refer your account to our collection agency, you agree to pay all of the collection, court costs and lawyer fees which are incurred.

RETURNED CHECKS: There is a late fee (Currently \$25) for any checks returned by the bank.

EFFECTIVE DATE: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force. ~ PLEASE CONTINUE TO BACK PAGE ~



2 Patient Information Form

SERVICES: All services provided are billable.

MEDICARE PATIENTS: Blue Sky Therapy is a Medicare certified facility and we will file a claim to Medicare on your behalf for covered expenses. You will be responsible for any co-insurance, deductibles and non-covered expenses. Medicare regulations require that all procedures be accompanied by signed physician orders.

PRECERTIFICATION: Please inform us if Pre-Certification is required by your insurance carrier. Failure to do so may reduce the amount otherwise payable by your insurance company.

CO-PAYS: Co-Pays are due and payable at time of service. Medicare considers "routine waiver" of co-payments against the law. Many other private insurers have adopted similar regulations. Therefore, in order to ensure that Blue Sky Outpatient Therapy complies with these regulations, waiver will be considered only for financial hardship. We appreciate your understanding in this extremely sensitive issue.

APPOINTMENTS: If you find that you cannot keep your scheduled appointment, we ask that you cancel at least 24 hrs in advance. Failure to cancel with less than 24 hrs notice or "no shows" will result in a cancellation fee of \$15.00 per appointment. This charge must be paid in full prior to rescheduling.

TESTING: It is the patient's responsibility to check with their insurance companies to make sure all testing is covered at this office. If your doctor ordered a test for you, please call your insurance company and MAKE SURE this test is a covered benefit through Blue Sky. If you fail to do so and your insurance company does not pay, the balance will become your responsibility.

CONSENT FOR TREATMENT/RELEASE OF INSURANCE ASSIGNMENT/RECEIPT OF HIPAA PRIVACY PRACTICES

Yes ___ No ___ I, the undersigned, hereby authorize the above provider to render any and all therapy service or any related service, that the provider feels are necessary or advisable to the patient in conjunction with physician referral.

Yes ___ No ___ I assign payment of medical benefits to Blue Sky Therapy.

Yes ___ No ___ I authorize the release of any medical information necessary to process this claim. I also give my authorization to release my records, progress notes and verbal reports if/when needed.

Yes ___ No ___ I acknowledge that I have received the HIPAA Notice of Privacy Practices (attached with this form).

Print Patient Name _____

Responsible Party (If different than patient) _____

Signature of Patient or Responsible Party _____

Date _____