

# Beck and Cale Physical Therapy /Coastal Hand and Occupational Therapy

- 201 N. College Dr. ,Ste. 203, Santa Maria, CA 93454 (805) 922-1724 (805) 922-2765-fax
- 150 Mary Ave Ste 1 Nipomo, CA 93444 (805) 929-3230 (805) 929-3232-fax
- 2028 Village Ln., Ste. 102 B, Solvang, CA 93463 (805) 686-4642 (805) 576-7961-fax

## PATIENT INFORMATION INTAKE. Please complete each section.

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_ SEX:  F  M

Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_ Driver Lic. # \_\_\_\_\_

Mailing Address: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Email address \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_

Employer's Name/Address: \_\_\_\_\_

In case of emergency/notify: \_\_\_\_\_ Relation \_\_\_\_\_ Phone # \_\_\_\_\_

**REFERRING PHYSICIAN:** \_\_\_\_\_ Phone # \_\_\_\_\_

Do you have a follow up appointment?  NO  YES, when? \_\_\_\_\_ Primary Physician \_\_\_\_\_

## **INSURANCE BILLING INFORMATION: Please notify the billing office of any insurance or benefit changes immediately.**

**Type of injury:**  Work Related  Auto Accident  Other Date of Injury/Onset \_\_\_\_\_ Surgery Date \_\_\_\_\_

If minor, responsible party name: \_\_\_\_\_ DOB \_\_\_\_\_ SSN \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Phone # \_\_\_\_\_

ID# \_\_\_\_\_ Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Phone # \_\_\_\_\_

ID# \_\_\_\_\_ Subscriber Name \_\_\_\_\_ DOB \_\_\_\_\_

Workman's Comp/Personal Injury Insurance Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Claim # \_\_\_\_\_ Attorney Name \_\_\_\_\_ Phone # \_\_\_\_\_

## **FINANCIAL POLICY. Please read, initial and sign. If it has been a year from your last visit you will be asked to sign consent forms.**

\_\_\_\_ I understand that all copays and deductibles must be paid at the time of service. As part of our contract with the insurance payers we are legally required by the terms of the contract to collect copays and deductibles at the time of service. If we are not billing any insurance payer and you are paying cash for services, payment is due at the time of service.

\_\_\_\_ I understand that BCPT/CHOT will submit a claim for the patient to the contracted insurance payer. **HOWEVER, ANY NON-COVERED SERVICES BY THE INSURANCE PAYER WILL BE THE PATIENT'S RESPONSIBILITY.**

\_\_\_\_ I understand that the office requires a 24 hour cancellation notice. Failure to do so will result in a **\$45 NO SHOW CHARGE**, payable at next scheduled visit. This fee is not covered by your insurance.

\_\_\_\_ I understand that it is mandatory to notify the billing office of any insurance or benefit changes immediately.

\_\_\_\_ I understand that there will be a **\$25 charge** for a returned check. This amount will be in addition to your open balance.

\_\_\_\_ I understand that any outstanding balance over 90 days past due is considered delinquent. You will be sent a final notice letter to pay the account in full within 15 days. If any balance remains unpaid, we may defer the delinquent account to a collection agency and you may be discharged from the practice.

\_\_\_\_ I consent to bill my health insurance payer directly, or from another insurer for the services provided to me or my children under the age of 18 years old. This may include determination of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services for the purpose of reimbursement. This information may also be used for billing, claims management, collections and related health care data processing through this practice. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. I have read and understand the payment policy of Beck and Cale Physical Therapy/Coastal Hand and Occupational Therapy and agreed to abide by its policy guidelines.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_