INSPIRE
PHYSICAL & HAND THERAPY

Patient Information

Last Name _____ First Name _____ MI _____

Mailing Address _____

City _____ State _____ Zip _____

Email Address _____

Home Phone (_____) _____-_____Cell (_____) _____-_____ Work (____) _____- _____

Date of Birth ____/____/_____ SSN _____ Gender _____ Marital Status _____

How Did You Hear About Inspire? (Please check the box that best applies)

❒ Referred by Doctor ❒ Past Patient ❒ Internet/Google Search ❒ Recommended by Family/Friend

❒ Instagram ❒ Facebook ❒ School Ad: _____ ❒ Event: _____
(School Name) *(Name of Event)*

❒ Other: _____

Emergency Contact

Last Name _____ First Name _____

Relationship_____ Phone (_____) _____ _____

Employer

Name _____ Phone (_____) _____ _____

Mailing Address _____

City _____ State _____ Zip _____

Authorization to Treat, Release Information, and Assignment of Insurance Benefits

I hereby authorize Inspire Physical & Hand Therapy to evaluate and treat me (or my dependent). I authorize Inspire Physical & Hand Therapy to release to my insurance company(ies) any medical information necessary to process my insurance claim. My signature also authorizes any insurance benefits to be paid on my behalf to the providers at Inspire Physical & Hand Therapy. I hereby agree to full responsibility for all expenses incurred by myself, or minor child.

Financial Policy and Agreement

1. Insurance co-payments are required at check-in. We may pre-collect for services if your annual deductible hasn't been met. We accept most major credit cards, cash, and check. Payment plans are available.
2. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. To facilitate claims processing, you must provide all insurance policy information and any changes to your insurance. Your bill is your responsibility, whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claims. You are responsible for knowing what your insurance does or does not cover and the providers and network(s) covered by your insurance company. You will be billed for any service provided, but not covered by, your insurance company.

Notice of Privacy Practices Acknowledgement (HIPAA)

We keep a record of the health care services we provide you. You may ask to see and receive a copy of that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you may access your information.

Other parties whom you would like to receive information on your behalf (not insurance companies):

_____

No-Show/Late Cancellation Policy

At Inspire Physical & Hand Therapy, we value our time with our patients and believe that keeping your appointment is an integral part of your recovery. **Please be advised, a minimum of 24 hours' notice is required if you need to cancel an appointment. Not showing for an appointment or cancelling with less than 24 hours' notice may result in a fee of $50.** After two missed appointments, you may be placed on a same-day call in basis. This means you will have to call in the morning for an appointment that day. We may not be able to accommodate all same-day call in requests.

Message Authorization

I authorize IPHT to leave detailed information on my phone: Mobile: ◉ Yes ○ No Home: ◉ Yes ○ No

Initials: _____

I have read and acknowledge the above statements with my signature below.

Signature: _____ Date: _____