

SOUTHSIDE PHYSICAL THERAPY, INC.

Please bring to your 1st visit:

- Prescription for therapy from the Dr.
- Medical Insurance card(s)
- Picture ID
- Worker=s comp letter with claim #
- Auto insurance letter with claim #

Patient Last Name	First	MI	Date of Birth	Age	Social Security No.
Address	Mailing Address (if different)		City	Zip	
Home Phone	Cell Phone	Place of employment / work phone			
Emergency contact, Phone No. (relationship)			Referring Physician	Primary Physician	

Responsible Party and/or Policy Holder:

Last name	First	MI	Date of Birth	SS#
Address	City	Zip	Home Phone	
Place of Employment	Work Phone			

Insurance / Billing Information

Payment Options offered by this office:

- 1) Payment in full by cash, check, Visa, Mastercard on day of service.
- 2) Use of your medical insurance, with payment of your **estimated** co-insurance portion (% that is patient=s responsibility) at the time of service. Balances billed to patients are due in 30 days. **Late payment past 30 days will be subject to a 1.5% interest charge, 18% annually, added monthly to the past due balance.**

Each insurance company determines their individual level of payment, often having multiple payment levels depending upon your particular policy.

Patients should remember that professional services are rendered to a person, and not to an insurance company. Thus, the insurance company is responsible to the patient, and the patient is responsible to the clinic. We will help in every way we can by filing your claim and answering your questions. Patients are encouraged to stay in contact with their insurance company regarding co-insurance, claim processing, or other questions about insurance reimbursement.

Type of Insurance(s) circle: Private Medicare OHP (Oregon Health Plan)
Worker's Comp. Date of Injury _____ Automobile Date of accident _____

If we are treating injuries that occurred due to an on-the-job or auto accident, please bring a letter from your Worker's Compensation company or Auto Insurance company that includes a claim # and other information for billing purposes.

Patient # _____