

PROFESSIONAL THERAPIES OF ROANOKE, INC.

1421 Third Street, SW, Roanoke, VA 24016

Billing Office (540) 982-2208

Blacksburg (540) 961-1230

Lancerlot (540) 343-0466

Moneta (540) 297-7867

Daleville (540) 992-4801

Westlake (540) 721-4199

Shawsville (540) 382-1492

Rocky Mount (540) 484-1456

Christiansburg (540) 382-1492

Please verify the following information:

PATIENT'S

NAME: _____
(last) (first) (middle)

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME TELEPHONE NO.: _____ SOCIAL SECURITY NO.: _____

DATE OF BIRTH: _____ AGE: _____ SEX: M/F _____

Please provide the following:

EMPLOYER: _____ E-MAIL ADDRESS: _____

EMPLOYER'S ADDRESS: _____ WORK TELEPHONE NO.: _____

**

PERSON TO NOTIFY IN CASE OF EMERGENCY: _____ PHONE NO.: _____

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SPOUSE'S (Parent or Guardian if Patient is a Minor)

NAME: _____

EMPLOYER: _____ POSITION/TITLE: _____

EMPLOYER'S ADDRESS: _____ WORK PHONE NO: _____

SOCIAL SECURITY NO: _____ DATE OF BIRTH: _____

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AUTO ACCIDENT INJURY INFORMATION

(Only complete this section if you are being treated due to an auto accident)

DATE OF ACCIDENT: _____ PATIENT'S POLICY OR CLAIM NO.: _____

BILLING INFORMATION: NAME OF INSURED: _____

INSURED'S INSURANCE COMPANY NAME AND COMPLETE ADDRESS: _____

NAME OF ADJUSTER: _____

IS THERE AN ATTORNEY ASSISTING YOU WITH THIS CLAIM?: _____ IF SO, PLEASE GIVE NAME, ADDRESS, AND TELEPHONE

NO.: _____

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Co-insurance and deductibles for services are due at the time services are rendered. We accept cash, checks, Mastercard, or Visa. Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1½% per month.

We will gladly discuss your proposed treatment and answer any questions relating to your plan of care. We will answer any insurance questions we can...

You must realize however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services and certain diagnoses they will not cover. If we inform you that a certain form of treatment is not covered and you choose to receive it anyway, you will be responsible for the entire charge for that portion of your treatment.
3. Your insurance company may place limits on certain types of treatment (eg., PT or OT) and/or on certain specific modalities used (eg., manual therapy). It will be necessary for you to keep up with these limits because any treatment exceeding these limits will have to be paid directly by you.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. You must inform us regarding any changes in your insurance coverage on or before the effective date of the change. Since many insurances require pre-authorization, we must obtain this or you will be responsible for the full cost of the services.

If you have any questions about the above information or any uncertainty regarding insurance coverage, **PLEASE** do not hesitate to ask us. We are here to help you.

PATIENT'S CONSENT AND FINANCIAL RESPONSIBILITY

I hereby authorize Professional Therapies of Roanoke, Inc. to obtain-release information needed to process insurance claims; coordinate my care with other care providers and/or to gather pertinent medical documents to insure my safety. I authorize Professional Therapies of Roanoke, Inc. to bill and to collect from my insurance companies. I understand that I have the right to revoke this authority at anytime by doing so in writing. I hereby consent to the treatment prescribed by my physician and understand that I am ultimately responsible for all bills generated from such treatment.

I have received a copy of the PTOR Attendance Policies and Procedures and am willing to accept responsibility to follow these guidelines concerning attendance at therapy sessions.

As a patient of Professional Therapies, Inc., I have been provided with a copy of Professional Therapies notice of Privacy Practice to be reviewed. I have been informed that should I have questions regarding Professional Therapies Privacy Policy or do not understand information in the policy that I may direct these questions to a Compliance Officer. If I choose, I may request a paper copy of the notice for my personal records.

Patient Signature

Date: _____