HIGGS PHYSICAL THERAPY
Livingston
29565 South Frost Rd. Suite A
Livingston, LA 70754
225-435-0550 • Fax 225-435-0551

PONCHATOULA THERAPY
PHYSICAL - OCCUPATIONAL - SPEECH
132 S 6th Street
Ponchatoula, LA
985-386-6884 • Fax 985-386-6854

☐ Please Check Your Attending Location ☐

PATIENT INFORMATION

Name: (First)_____(Last)_____(MI)_____(Jr., Sr., Etc.)

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Mailing Address:_____City: _____ State: _____ Zip Code: _____

Date of Birth: _____ Age: _____ SSN: _____ Gender: M or F

Driver's License #:_____State:_____Marital Status:_____

Employer:_____Occupation:_____Employer's Address:_____

Patient's Email Address: _____

EMERGENCY CONTACT INFORMATION

EMERGENCY CONTACT: _____ Relation: _____

Home Phone: _____Work Phone: _____Cell Phone: _____

INSURANCE INFORMATION

Primary Ins: _____ Insured Name: _____ DOB: _____ SSN#: _____

Secondary Ins:_____ Insured Name: _____ DOB: _____ SSN#: _____

On the Job Injury? ☐ Yes ☐ No Date of Injury: _____Claim#: _____

Worker's Comp. Insurance Co.: _____ Adjuster's Name: _____

Auto Accident? ☐ Yes ☐ No Date of Injury: _____Claim#: _____

Auto Insurance Co.: _____ Adjuster's Name: _____

Do you have an Attorney pertaining to this injury? ☐ Yes ☐ No

Attorney's Name: _____ Attorney's Phone #: _____

PREVIOUS THERAPY INFORMATION

Have you received any other Therapy Services this Calendar Year? ☐ Yes ☐ No Last Date Seen: _____

Have you received, or are you currently receiving Home Health Therapy? ☐ Yes ☐ No

If yes, please provide the name of the Home Health Agency: _____ and the Discharge Date: _____

Have you received, or are you currently receiving Chiropractic Treatment? ☐ Yes ☐ No Last Date Seen: _____

I hereby authorize payment of medical benefits to Ponchatoula Therapy, LLC/ Higgs Physical Therapy, for services rendered to me. I also hereby consent to the treatment and care as prescribed by my physician and / or recommended by the therapist. I also authorize the therapist to release any information during my evaluation or treatment. This assignment will remain in effect until revoked by me in writing. A photocopy is to be considered as valid as the original. **I hereby accept Financial Responsibility for all charges incurred whether or not I have insurance coverage. Verification of benefits we receive from your insurance company is NOT a Guarantee of Payment.**

_____

Patient or Responsible Party's Signature **Date**

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ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of Ponchatoula Therapy, LLC / Higgs Physical Therapy notice of privacy practice. By signing below, I am giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_____

Print Patient Name Patient's Date of Birth

_____

Signature of Patient or Parent/Legal Guardian Date

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PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand PONCHATOULA THERAPY, LLC'S Notice of Information Practices. I understand that PONCHATOULA THERAPY, LLC / Higgs Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that PONCHATOULA THERAPY, LLC / Higgs Physical Therapy will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby acknowledge to the use and disclosure of my personal health information for purposes as noted in PONCHATOULA THERAPY, LLC's / Higgs Physical Therapy's Notice of Information practices. I understand that I retain the right to revoke this acknowledgement by notifying the practice in writing at any time.

_____

Patient Name

_____

Signature

_____

Date

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Financial Policy

Please Read Carefully:

1. **Payments –** Copayments and Payments for services are due at the beginning of EACH visit. If you have a deductible or coinsurance, we will estimate your responsibility to be paid on each visit and you will be billed or credited any balance as applicable once all claims have processed. **We are unable to waive patient responsibility, this includes copays, coinsurance, and deductibles. We accept cash, checks, MasterCard, Visa, or Discovery.**

2. **Benefit Limits-** Some insurance plans have a financial or visit limit for physical therapy services. It is ultimately your responsibility to know your benefit limits. We have procedures in place to help you stay within any limits, but again it is your responsibility to keep track of your limits. If you exceed your limit you will be responsible for charges not paid by your insurance company due to the exhaustion of your benefits.

3. **In Network/ Out of Network-** Your insurance is a contract between you, your employer and your insurance company. We are participating provider for most insurance companies. If we are in network, we will charge you no more than our contractual rate with your insurance company. If we are out of network with your insurance company and your claims are submitted to your insurance company, you will be responsible for all reasonable and customary charges as indicated on the explanation of benefits received from our insurance company. For more clarification on this, please speak with our Office Manager.

4. **Accidents-** If your injury is Work Related or due to an auto accident you must provide our office with your claim number, adjuster's name, and phone number before you initial visit.

Our relationship is with you, not your insurance company. All charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment on your account. If such problems do arise, we encourage you to contact us promptly for assistance in management of your account. Should your account become delinquent, we will no longer continue to schedule additional visits until balance is paid in full.

I, _____ **Have read and understand the above policies on**_____.

Patient or Responsible Party Signature Date

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Assignment of Benefits / Release of Information

I do hereby assign all medical coverage and payable benefits to which I am entitled, to be paid directly to Ponchatoula Therapy, LLC / Higgs Physical Therapy. I agree that if payment is mistakenly issued to me by my coverage entity, that I shall immediately remit the afford mentioned payment to Ponchatoula Therapy, LLC for services rendered. I acknowledge that a photocopy of this document is to be considered as good as the original.

I do give my consent for Ponchatoula Therapy, LLC to obtain a quote of benefits from my individual coverage entity. A quote of benefits is not intended to be a guarantee of coverage and/or payment. All claims are subject to medical necessity, terms, conditions and contract limitations of the policy in force at the time that services are rendered. A final determination of payment will be made at the time of review.

I understand and that in the event my insurance entity denies or refuses to issue payment for services rendered, regardless of cause or reason, that I will assume full financial responsibility for the services that have been received.

Deductible _____Deductible Met _____Copay _____Co-Insurance_____

Payment Arrangements_____
_____
_____

_____ _____
Patient Signature Clinic Representative

_____ _____
Date Date