

# St. Charles Sports & Physical Therapy

Where Great Comebacks Begin...

St. Charles  
St. Peters  
O'Fallon  
Wentzville

## 1 PATIENT INFORMATION

Date \_\_\_\_\_

Patient \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Street

Apt. #

Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

City

State

Zip

Email Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex:  Male  Female Age \_\_\_\_\_

Employer \_\_\_\_\_ Referring Physician \_\_\_\_\_

Employer Address \_\_\_\_\_ Office Location: \_\_\_\_\_

Primary Physician \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Office Location: \_\_\_\_\_

### In Case of Emergency contact: (Please list person not living with patient)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Date of 1st. Symptom or Injury \_\_\_\_\_ Was this an accident?  Yes  No

Accident Type  Work  Auto  Other Rehab Nurse/Case Manager \_\_\_\_\_

Phone # \_\_\_\_\_

## 2 INSURANCE

Subscriber \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

Date of Birth \_\_\_\_\_

Employer \_\_\_\_\_ Employer Address \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Employer Phone # \_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

**Is Patient covered by additional insurance?**  Yes  No

Insured Person \_\_\_\_\_ Relationship \_\_\_\_\_

Date of Birth \_\_\_\_\_

Insurance Co. \_\_\_\_\_ ID # \_\_\_\_\_ Group # \_\_\_\_\_

### 3 Admission Agreement

**Consent to Medical and Related Health Care:** I request and consent to the medical care and treatment procedures as determined necessary by my physician(s). I acknowledge the care I receive while in this facility is under the direction of my physician(s).

**Medical and Allied Health Care Providers:** I have been informed and understand that the Physical/Occupational Therapist providing services to me in this facility are not independent contractors and are employees of this facility unless otherwise specifically identified.

**Assignment of Benefits:** I hereby irrevocably assign and transfer to **THIS FACILITY** any and all benefits, either contractual, common law, or statutory, to which I am entitled or which are available to me under any medical, health, and accident, or workers' compensation policy, plan, or program. I hereby authorize and direct that any such payments be paid directly to **THIS FACILITY**. I understand that I am financially responsible for all charges whether or not paid by insurance. In the event of non-payment I agree to pay all reasonable costs (collection agency, attorney fees, and/or court costs) incurred by the clinic or its representative for collection of said payment. I hereby authorize St. Charles Sports & Physical Therapy to release all information necessary to insurance, attorney or adjuster, to secure the payment of benefits. I give assignment and lien against any claims a third-party whose negligence may have caused the patient's injury, up to the amount of the bill for services. I authorize the use of this signature on all insurance submissions..

**Cancellations or Late Arrivals:** I understand, if possible, I will contact, **THIS FACILITY** for cancellations or late arrival. I understand two (2) consecutive missed appointments without notification may result in cancellation of all future appointments. I further understand if circumstances require my late arrival for the scheduled appointment, I may be asked to re-schedule.

I understand that it is my responsibility to obtain and know my physical therapy benefits (deductible, co-pay, co-insurance, maximum visits) as outlined by my health insurance policy.

I have read and understand the above agreement.

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Patient/Responsible Party Signature	Relationship	Date
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**If patient is a minor:**

I give consent for treatment of the above named minor child by *St. Charles Sports & Physical Therapy*.

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Signed	Parent/Legal Guardian	Date
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**For Medicare Patients Only**

I request that payment of authorized Medicare benefits be made either to me or on my behalf to St. Charles Sports & Physical Therapy, Inc. for any services furnished to me by that provider. I authorize any holder of Medicare information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable related services. I understand my signature requests that payment be made and authorizes release of Medicare information necessary to pay the claim. If "other health insurance" is indicated in item #9 of the HVFA-1500, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, co-insurance and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

I have read and understand the above agreement.

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Beneficiary Signature	Medicare #	Date
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