ALLIANT
PHYSICAL THERAPY GROUP

Clinic: _____ DX Code(s): _____

PATIENT INFORMATION

TODAY'S DATE: _____

NAME: _____ MALE FEMALE (circle one)
(LAST) (FIRST) (M.I.)

ADDRESS: _____
(CITY) (STATE) (ZIP CODE)

BIRTHDATE: _____/_____/_____ AGE: _____ SOCIAL SECURITY NUMBER: _____/_____/_____

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____ *E-MAIL: _____

EMPLOYER: _____

Who is responsible to pay for services rendered?
___Self Pay ___Personal Insurance ___Work Comp Insurance ___Attorney

Is this a Work Comp injury? ___Y ___N If yes, what is the date of injury?_____

Is this an auto accident injury? ___Y ___N If yes, what is the date of injury?_____

NAME OF PRIMARY INSURANCE: _____

POLICY HOLDER'S NAME: _____ RELATIONSHIP: _____

POLICY HOLDER'S SOCIAL SECURITY NUMBER: _____/_____/_____ BIRTHDATE: _____/_____/_____

POLICY HOLDER'S EMPLOYER: _____

SECONDARY INSURANCE or ATTORNEY: _____

INSURANCE CONTACT PERSON: _____ PHONE: _____

Referred by: _____ Family Physician: _____

IN CASE OF EMERGENCY NOTIFY: _____ ***PHONE:*** _____

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AUTHORIZATION FOR TREATMENT: I give my consent to undergo examination and treatment by the staff at **Alliant Physical Therapy.**
PATIENT SIGNATURE: _____ DATE: _____

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AUTHORIZATION TO RELEASE AND ASSIGN INSURANCE BENEFITS

I authorize the release of any information required to act on this claim and permit photographic or other facsimile reproduction of this authorization to be used in place of the original. I hereby assign to **Chad Novasic PT., LTD.**, doing business as **Alliant**, the medical benefits I am entitled to for Physical Therapy services from my insurance company. I understand **I am responsible for any charges** not paid for by my insurance company. *By listing my email address and cell phone number I authorize Alliant Physical Therapy Group to send emails and text messages to me.

PATIENT SIGNATURE: _____ DATE: _____

Alliant Physical Therapy
Billing Information

Insurance

We are in many health plans even though we may not be listed in the book. To help with this you need us to check using our Federal ID number.

We bill your insurance as a courtesy to you. We try our best; however you also have some responsibility to work with your insurance company to help assure payment of your bills.

You will receive a statement from our office after we have heard from your insurance company. This should reflect payment made by your insurance company and your responsibility. Payment is expected within 30 days of this statement.

We pride ourselves as being high quality providers of Physical Therapy services. Insurance companies are using "medical necessity" as a way to deny benefits. Unless otherwise contracted, we do not accept "not medically necessary" as an excuse to not make payment.

Clinic Name
The Clinic name is ***Alliant Physical Therapy***; however the corporate name is registered as ***Chad Novasic, P.T. Ltd.***

Attorney
If you have an attorney we will accept a letter of protection for outstanding balances not covered by your insurance company. If you have an attorney we expect your cooperation in helping us collect from your insurance company. Failure to cooperate will result in us sending bills directly to you and demanding payment within 30 days. Medicaid/T19 will not be accepted as insurance in litigation cases. A letter of protection from your attorney will be required for treatment.

Financial hardship
We are in the business of helping people. Should you have some difficulty paying your bills, we will work with you to help you create a plan that you can live with. Finances should not limit your health care decisions. Please contact the billing department at 262-260-8877.

Our Promise
We promise to do our best to help your rehabilitation process on each and every day. We cannot guarantee results, but we can give you our best!

Please sign. I have received this statement:

_____ _____ _____
Print Name Signature Date

Financial Responsibility Disclosure

I understand and agree that services have been rendered **for which I am fully responsible**, whether or not medical or other insurance should cover the cost of at least a portion of the services rendered, and I further understand and agree that in the event that I default on any payment due and owing Alliant Physical Therapy Group for such services, **I will pay any and all costs of collection** of such payments due and owing.

Agreed to as of the date signed below:

_____
Signature of Patient or Legal Representative

_____
Date