GINDI PHYSICAL THERAPY

1002 N. Woodland Drive
Lancaster, SC, 29720
Phone: 803.282.9390
Fax: 803.282.9391
www.GindiPT.com

Parent/Guardian/Spouse/Domestic Partner

First Name	Middle Name	Last Name

Sex	Marital Status	Date of Birth	Social Security Number

Address	City	State	Zip

Home Phone	Cell Phone	Work Number	Ok to call at work?

Primary Medical Insurance/Work Comp Insurance/Auto Insurance

Insurance Company Name	ID #	Group #

Street Address	City, State, Zip	Phone #

Name of Subscriber,(MUST HAVE name, SSN, DOB to bill)	Social Security #	Subscriber's Date of Birth

Work Comp and Auto Insurance Only Date of Accident: Claim's Adjuster Name:

Secondary Medical Insurance

Secondary Insurance Name	ID#	Group #

Street Address	City, State, Zip	Phone #

Name of Policy Holder	Social Security #	Date of Birth

Emergency Contact Information

Name	Relationship	Phone #

Address	City	State	Zip

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AGREEMENT TO PAY FOR TREATMENT

I, the responsible party, hereby agree to pay all the charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization, with which this office had a contractual agreement, I agree to pay all applicable co-payments, co-insurance and deductibles, which arise during the course of treatment for the patient. The responsible party also agrees to pay for treatment rendered to the patient, which is not considered to be a covered service by my insurer and/or a third party insurer or other payor. I further understand that if I do not show for an appointment or do not give 24 hours notice to Gindi PT when canceling an appointment I may be responsible for the charges up to the potential cost of the visit.

X _____

RESPONSIBLE PARTY **DATE**

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RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER

I, hereby authorize GindiPT, and its employees to release and disclose, all or any part of the patient's medical records to any entity which is, or may be liable, for all or part of the provider charges.

I, authorize the release and disclosure of any and all of my, or my child's, medical records to any other entity, including, but not limited to specialty physicians, hospitals, or other health care providers which may be of assistance in the opinion of this office, in providing treatment of the patient.

I, authorize the release of records necessary to assist in the reimbursement of benefits to which I may be entitled.

I, authorize this office and/or its employees to release, via fax or other secure electronic means, medical records which are needed in order to provide the patient with the most appropriate medical care.

I, authorize and request that payment of any third party or insurance company benefits be made directly to Arbor Family Medicine, PC for any services furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

X_____

RESPONSIBLE PARTY **DATE**

CONSENT FOR TREATMENT

By signing below, I, the undersigned patient (or authorized representative) consent to and authorize the performance of any treatments, examinations, medical services, surgical or diagnostic procedures, including lab and radiographic studies, as ordered by this office and it's healthcare providers. "I give permission to be called on the telephone numbers I have given as well as text messages or email. This includes calls with pre-recorded messages, dialing systems, artificial voices. Calls may be made by business helping my providers collect money I may owe. I give permission to share my information with the following people:

_____ _____

_____ _____

X_____Date_____

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***Patients with Health Plans, please present your insurance ID Card to the receptionist after completing this form.**

***Some contract Health Plans (HMO, PPO, IPA, etc) require a co-payment at the time of service-Please have this ready prior to your visit as well. as any current balance due. If copayor past due balance is not paid at the time of visit, patient may be required to reschedule the appointment.**