



12006 W. 87th St. Pkwy
Lenexa, Kansas 66215

913.601.8151 | PWRPHYSIO.COM

PATIENT NAME _____

DATE OF BIRTH _____ SEX _____ SSN _____

ADDRESS _____ APT # _____

CITY _____ STATE _____ ZIP CODE _____ PHONE # _____

EMAIL _____

***** ARE YOU CURRENTLY RECEIVING HOME HEALTH SERVICES? YES / NO *****

HOW DID YOU HEAR ABOUT US? _____

PRIMARY CARE PHYSICIAN _____

REFERRING PHYSICIAN _____

EMERGENCY CONTACT _____

PHONE # _____ RELATIONSHIP _____

PRIMARY INSURANCE _____

MEMBER ID # _____ GROUP # _____

COPAY \$ _____ CO-INSURANCE \$ _____

REMAINING DEDUCTIBLE \$ _____ ESTIMATED COST PER VISIT \$ _____

ARE YOU THE PRIMARY SUBSCRIBER? YES / NO

IF NO, SUBSCRIBER'S NAME _____

SUBSCRIBER'S DATE OF BIRTH _____ RELATIONSHIP _____

SECONDARY INSURANCE _____

MEMBER ID# _____ GROUP # _____

CO-INSURANCE % _____ REMAINING DEDUCTIBLE \$ _____

ARE YOU THE PRIMARY SUBSCRIBER? YES / NO

IF NO, SUBSCRIBER'S NAME _____

SUBSCRIBER'S DATE OF BIRTH _____ RELATIONSHIP _____



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**** DO YOU WANT US TO BILL YOUR INSURANCE FOR SERVICES RENDERED? YES / NO ****

**** DO YOU AGREE TO PAY ALL COPAYS, DEDUCTIBLES, PATIENT RESPONSIBILITIES AND CANCELLATION FEES AS APPLICABLE AT THE TIME OF SERVICE? YES / NO ****

**** DO YOU WANT TO SELF PAY FOR SERVICES RENDERED? YES / NO ****

SELF PAY COST PER VISIT \$ _____

ONCE THE PAYMENT TYPE IS DETERMINED, WE ARE NOT ABLE TO CHANGE THE BILLING PROCESS

PAYMENT INFORMATION

WE ASK THAT YOU PAY FOR TREATMENT AT THE TIME OF YOUR VISIT. REGULAR EXCEPTION TO THIS POLICY ARE THOSE PATIENTS WITH WORKER'S COMPENSATION OR OTHER INSURANCE WHICH IS CONFIRMED FOR FULL PAYMENT. IF YOUR INSURANCE POLICY PAYS 80% AFTER YOUR DEDUCTIBLE, WE WILL ASK FOR PAYMENT UP TO THE AMOUNT OF THE DEDUCTIBLE PLUS 20% THEREAFTER. IT IS THE PATIENT'S RESPONSIBILITY TO CONFIRM THE POLICY PAYMENT. PLEASE OBTAIN CLAIM FORMS FROM YOUR INSURANCE COMPANY, FILL THEM OUT AND PRESENT THIS TO US FOR OUR BILLING.

EXCEPTIONS TO THIS ABOVE POLICY CAN BE MADE WITH *PRIOR APPROVAL* FOR EXAMPLE, PATIENTS WHO ARE SEEN FOR DAILY TREATMENTS MAY WISH TO PAY WEEKLY RATHER THAN DAILY. PAYMENT PLANS FOR PATIENTS WITHOUT INSURANCE OR IN FINANCIAL DIFFICULTY MAY BE SET UP WHEN NECESSARY. IF AN ACCIDENT CASE IS IN LITIGATION, WE ADHERE TO THE ABOVE POLICY AND *DO NOT WAIT* FOR PAYMENT WHEN THE COURT CASE IS CLOSED.

AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST

I AGREE TO BE EVALUATED AND TREATED FOR PHYSICAL/OCCUPATIONAL THERAPY. I HEARBY CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVII OF THE SOCIAL SECURITY ACT IS CORRECT. I AUTHORIZE RELEASE OF ALL RECORDS REQUIRED TO ACT ON THIS REQUEST. I REQUEST THAT PAYMENT OF BENEFITS BE MADE ON MY BEHALF TO PWR PHYSIO LLC. I UNDERSTAND THAT I MAY REQUEST A COPY OF THE PRIVACY PRACTICES AND/OR COPY OF MY PROTECTED HEALTH INFORMATION.

SIGNATURE _____ **DATE** _____

**** IS THIS INJURY A RESULT OF AN AUTO ACCIDENT? YES / NO ****

**** IS THIS A WORKER'S COMPENSATION CASE? YES / NO ****

CONTACT PERSON FOR THE CASE _____ PHONE # _____

CASE # _____

EMPLOYER NAME _____

EMPLOYER ADDRESS _____

EMPLOYER PHONE # _____